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ABSTRACT

This curriculum guide, written to assist health professionals in developing classes for parents of children from birth to 24 months of age, consists of three main sections. The first section, "Preparing for Your Audience," outlines some prerequisites the instructor should take into account when planning learning experiences for adults, discusses how these prerequisites can be met, and suggests resources for generating information concerning parents' interests and needs. The second section, "Family Issues," is designed to serve as a guide and resource for initiating the process of helping parents deal with problems that often stand in the way of their own growth and development. This section includes teaching outlines on the issues of family systems and decisions concerning work and child care, along with a variety of resources related to these issues. The third and final section, "Infant and Toddler Growth and Development," gives ideas for planning a series of classes or workshops either by topic or by age grouping, whichever best meets the needs of the potential participants. As in the second section, the third section includes teaching outlines and a variety of resources related to infant development and health. (MP)

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New Parents

Guidelines for Teaching Infant-Toddler Growth and Development

Birth - 24 Months

Minnesota Department of Health
& Toys 'n Things

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Blueprints by Susan Middleton, Toys 'n Things Press, St. Paul, MN 1981

- Constructing The Content: Classes
- Designing The Framework: Needs Assessment

Health, Safety and First-Aid Training Guide by Audrey Robertson, Toys 'n Things Press, St. Paul, MN 1980

- General Signs and Symptoms of Illness
- Health Concerns -- Health Hints
- Health and Safety Books for Toddlers

Homebased Training Resource Handbook edited by Debra Fish, Toys 'n Things Press, St. Paul, MN 1980

- Sharing in the Caring
- Disciplining the Infant and Toddler
- Accident Prevention and Child Safety
- Toilet Training/Toilet Learning

Infant-Toddler Growth & Development by Audrey Robertson, Toys 'n Things Press, St. Paul, MN 1979

- Directions For Making: The Baby's Most Important Resource
- Books For Babies

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FORWARD

Professionals in most health disciplines are increasingly pursuing a "holistic" approach to prevention and treatment. Many health professionals are choosing this same approach when developing strategies for dealing with child abuse and neglect. Classes for new parents are becoming part of that strategy. Classes on child growth and development are being used to help parents come to understand the range of "normal" behaviors in children and to develop age-appropriate expectations for their children. Classes help parents develop and/or refine their child care skills in ways that make parenting less stressful. Through the classes, parents often meet others with similar concerns and act as supports for each other. Thus classes can help to reduce the stress and social isolation that is characteristic of parents who become abusive or neglectful. However, the benefit of learning opportunities for parents of infants and toddlers goes beyond the prevention of abuse and neglect. Classes can help parents experience the feeling of pleasure and excitement inherent in learning to observe and appreciate all the typical, as well as unique qualities of their baby.

This curriculum was written to encourage the development of classes for parents of children birth to 24 months of age. Health professionals* interested in this challenge can add creativity and imagination to develop a rewarding experience for parents and their infants and toddlers. When this happens, another step toward improving the overall health of babies and families will have been achieved.

*Note: This curriculum will be equally useful to other professionals interested in developing classes/workshops on infant and toddler growth and development. Instructors are encouraged to develop course offerings through, and to form linkages with, the adult vocational educational programs which serve Minnesota through the system of Area Vocational Technical Institutes (AVTI). For more information about planning and coordinating course offerings within the adult vocational education structure contact: Sharon Grossbach, Adult Vocational Program Manager, Department of Education, Capitol Square Building, 550 Cedar Street, St. Paul, MN 55101, 612-296-6516.

LEARNER OUTCOMES

Through the use of this curriculum, parents will be able to:

1. Compare their child's social, emotional, physical, cognitive, language development to the range of "normal" behavior for each of the above areas.

2. Predict the next steps in their child's development so that appropriate support and encouragement can be given to the following developmental phases.

3. Select, make and use toys, equipment, songs, games, books, and finger plays appropriate to their child's developmental stage.

4. Act preventively and reactively to health and safety considerations related to their child's developmental stage.

5. Provide a diet which satisfies nutritional requirements in concordance with the parents' values and child's developmental stage.

6. Increase their ability to cope with the normal behaviors of infants and toddlers which can at times cause the parent to lose control of his/her own behavior.

by Lori Wedeking
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New Parents

Guidelines for Teaching Infant-Toddler Growth and Development

Birth - 24 Months

Audrey S. Robertson

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Preparing For Your Audience

ON BEING THE ANSWER TO EVERY PARENT'S PRAYER

You are aware that there is a need for infant-toddler learning experiences for parents in your community. You have, therefore, decided to become actively involved in answering that need by creating classes and workshops on topics dealing with parenting infants and toddlers. Your next task then, is to determine how to most effectively and efficiently present information and facilitate learning experiences to meet those needs.

Whether you are a novice or have had considerable experience in helping adults learn, you may find it useful to review the following considerations, which should be taken into account when planning successful learning experiences for adults. These points are based on information found in Helping Others Learn[1], Planning, Conducting and Evaluating Workshops[2] and from the experiences gleaned by Toys 'n Things training staff in teaching adults, both in urban and rural settings, on a wide variety of early childhood topics.

Following the list of prerequisites for the instructor, is a section designed to aid the instructor in fulfilling those prerequisites. It consists of columns headed by 'Adult Learners Are:', i.e., characteristics of the adult learner, 'Effective Instruction Methods:', i.e., quality of instruction that works best when taking those characteristics into consideration, and a third column 'Implications for Planning This Class/Workshop', which has been left blank so that you can fill in specifically what you must keep in mind as you plan your class or workshop. The following example shows how the 'implications' will differ according to whom you have defined as your audience.

Adult Learners Are:	Effective Instructional Methods	Implications for Planning This Class/Workshop
People who react to their surroundings in various ways due to differing body conditions, life styles, etc.	Attempt to provide surroundings that suit the participants and include lots of coffee/ stretch breaks.	(For a class of adolescent parents) Space with carpeting, bean bag chairs, pillows, etc. to allow for being comfortable on the floor. Juice, crackers, fruit. (For a class of career oriented parents) Space with tables and comfortable chairs. Tea, coffee with cheese and crackers.

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[1] McLagan, Patricia A., Helping Others Learn: Designing Programs for Adults, published by Addison-Wesley Publishing Co., Reading, Massachusetts 1978.

[2] Davis, Larry N., Planning, Conducting and Evaluating Workshops: A Practitioner's Guide to Adult Education, published by Learning Concepts, Inc., 2501 North Lamar, Austin, Texas 1974.

Some prerequisites of the instructor:

1. An understanding of the characteristics of the adult learner.
2. An ability to "hook" and hold the participants' attention.
3. A knowledge of the learners' needs.
4. A thorough knowledge of the topic.
5. A preparation for ongoing and final feedback.
6. A thorough knowledge of available resources and the time required for ordering them.

The Class Participant/Adult Learner: A person who is in the process of changing in an effort to respond to new needs in his or her life.

The Instructor: A person with an understanding of the adult learner and appropriate resources, who is charged with the responsibility to facilitate the change that will fulfill the adult learner's needs.

Adult Learners Are:*	Effective Instructional Methods	Implications for Planning This Class/Workshop
People who are capable of changing.	Facilitate this change through offering a class or workshop.	
People who come to the learning situation with a certain amount of first hand experiences, and who have ideas to contribute.	Use the participants' experiences as a major resource.	
Looking for new experiences.	Provide new experiences and help the adult to convert those new experiences into learning.	
People who no longer need all the basics.	Help the participant as quickly and as directly as possible cope with the immediate problem and do not waste time on unnecessary foundation laying. Your needs assessment (see p.13) will help determine where to begin.	

* The instructor may wish to check Helping Others Learn, p. 53 for additional personal activities and characteristics that affect how adults learn and process information. See Bib. p. 35.

Adult Learners Are:	Effective Instructional Methods	Implications for Planning This Class/Workshop
People who have established habits and tastes.	Be sensitive to and attempt to accommodate as many of the participants' habits and tastes as possible.	
People who are capable of determining their own learning needs.	Use results of needs assessment data to plan a relevant course. (See handout Designing the Framework: Needs Assessment, p. 13.) And leave some room for participant input before finalizing a class schedule.	
People who have ideas about what constitutes a good learning experience.	Provide opportunities for participants to evaluate and provide objective feedback to the instructor both during a class (this is especially important if the class doesn't seem to want to jell) and at the end of the class, to help the instructor make appropriate changes for future classes/ workshops. See Evaluation Samples, p. 33.	
People who are often burdened and preoccupied by distractions coming from outside the learning experience.	Be sensitive to the participants' predicament providing a balance between presentation and time for the learner to integrate information.	
People who have definite feelings about learning situations and who respond best to positive reinforcement.	Recognize that everyone comes from learning experiences where they either succeeded or failed. Therefore, the class is built on appropriate reinforcement and filled with success experiences.	
People who have developed ways to use the group to meet their own needs.	Attempt to meet these individual needs in a way that is beneficial to the group.	

Adult Learners Are:	Effective Instructional Methods	Implications for Planning This Class/Workshop
People who have learned not to let their emotions show, but who sometimes find a class an environment acceptable for emotional release.	Do not encourage or discourage emotional release, but accommodate it appropriately, should it occur.	
People who have learned to selectively tune in/tune out what they do or don't wish to hear.	Take advantage of more than one sense system and find ways to involve the participants in the total learning experience.	
People who come with feelings from the past, e.g., guilts, regrets, nostalgia, etc.	Concentrate on providing new competencies, not on past failures or glowing memories.	
People who have repeatedly had to start over or make unforeseen adjustments due to such things as loss of job, death of dear ones, loss of responsibilities, children leaving home, divorce, etc.	Help the adult learn to live again, not just merely cope.	
People who are often confused by their options.	Help the learners make decisions appropriate for themselves.	
People who react to authority in different ways. Some resist it, some bow to it, some demand it, and others ignore it.	Assess the participants' reactions to authority and use authority appropriately.	
People with varying degrees of self esteem.	Strive to develop greater independence, self-direction, responsibility, and consequently greater self esteem in the participants.	

Adult Learners Are:	Effective Instructional Methods	Implications for Planning This Class/Workshop
People who will open themselves up to learning/change when they are given permission to express themselves.	Let the participants know that in this group feelings are okay, that they will get a non-judgmental hearing, etc. The instructor fosters group cohesion and trust building by including the participants in laying ground rules (which are open to change) at the first class.	
People who learn best when using a variety of their senses to receive and process information.	Make use of a judicious balance of lecture, demonstration, films/filmstrips, pamphlets, resource books, hands-on activities, (e.g., participants making things, practicing activities, researching information and sharing it with class, participating in small group discussions or tasks.) See Finding Resources to Enrich the Curriculum, p. 29.	
People who have individual styles of processing information falling into any of the following categories: Detail Learners, Main Idea Learners, Active Learners, Passive Learners, Analytical Learners, and Intuitive Learners.	Recognize that the differences in styles will cause; some to pick up details quickly but to have a difficult time grasping the larger picture; some to overview well but tend to ignore instructions or pay attention to supporting detail, and some to question and seek out data but sometimes jump to conclusions too quickly. There are some who want to have all information fed to them; some who do best in a highly structured, neatly organized situation, and some who like to deal with open ended learning situations. Note: (Since it is impossible to fully satisfy all of these styles, the instructor should not be surprised to get some very conflicting feedback on evaluations by a few individuals.) Plan enough flexibility into schedule to accommodate each style as often as possible.	

Adult Learners Are:	Effective Instructional Methods	Implications for Planning This Class/Workshop
People who react to their physical surroundings in various ways due to differing body conditions, life styles, etc.	Attempt to provide surroundings that suit the participants and include lots of coffee/ stretch breaks.	

CONSTRUCTING THE CONTENT: CLASSES

Planning Classes for Parents

Planning for classes and workshops pays. Effective planning is easier when you have a mental image of the variety of levels of experience adult learners have when they come to your program. Beginning classes in a community for parents have several advantages. This is the group of parents at greatest risk, the point at which intervention can be very cost effective. "Hands-on, how-to-do-it" classes are ideal for this group. An example would be a "Make-It, Take-It" class on stimulating toys for children, made from articles people have around the house. A workshop like that, which has adults actively involved, has numerous benefits besides the primary one of meeting the need for practical information to help survive each day with children and feel good about it. The fun, non-threatening format tends to heighten the comfort level of the participants. As they work on something, they can more easily talk to each other and share experiences and frustrations. The group interaction helps people discover that some of their feelings and experiences are not unique to them. This can mark the beginning of a peer support network.

Other pluses to this practical approach to classes for people at the beginning or survival level, is that parents have the opportunity to increase their confidence as they use skills they already have. They learn new ways to make those skills work for them and their children and at the end of the class have a tangible product they can use the very next day. During free-flowing discussion while people are making things, an instructor may also have the opportunity to do some informal needs assessment and cooperative planning for future course offerings. For instance, if during a class on "Healthy Snacks for Healthy Youngsters" the conversation should come around to whose children could do what at particular ages, it may be the time to ask the group if they would like to attend some sessions on ages and stages of child development.

The practical, activity-oriented approach to classes does work well, and continues to be successful and appealing because there are always new parents. But as people move from one stage to the next, their perceptions of what they need and want to learn about change. Once they begin to feel comfortable that they will survive tomorrow and the next day with their children, they will probably begin to look for theories behind what works well with kids, or what makes healthy families. The moving that people do from one stage to the next illustrates the need to expand the content of your program with offerings for each adult learning stage, unless services to meet the needs of people in those stages are already available through other community programs. A program that focuses primarily on Stage 1 must spend time continuously on recruiting new people. Programs that have choices for people at each stage in their parenting will have a broader-based and more consistent group of users.

As you make decisions about which developmental stages of adult learning your program will address, you will also be deciding which content areas will receive priority in programming.

Keep in mind the importance of meeting the needs of potential program users, <u>as they perceive them</u>. To get people coming, and to keep them coming to your program, they will have to be getting something they want out of it. So if your perception of what the community should have in the way of parent education

happens to differ from what people are telling you they want, offer what they think they need. It will probably happen that once your program is well-established, people will trust you and be open to recommendations you make about topics and issues you feel are valuable.

Carry the process of matching people's needs and interests with what your program offers one step further by following up on a valuable suggestion given by Larry Nolan Davis in his book, Planning, Conducting, and Evaluating Workshops.[2] Davis strongly recommends that at the beginning of any workshop, the instructor and the participants take time to talk over and agree on the objectives. By doing this, everyone knows what will happen during their time together, and participants have given their input regarding their needs and expectations. This process takes only a few mintues, and helps ensure that even the best-prepared workshop or class will be tailored to meet the needs of each specific group.

No matter what classes are offered, much of their success will depend upon the key element of "hospitality." As you plan for a class, think of the class members as honored guests. Planning for learning together is a lot like planning a party. You invite people, and then prepare so when they get there they will feel welcome, and there will be something for them to do that is in keeping with what their invitation led them to believe might happen. When people are at the party (or class), this means making sure things go as planned, or that the plan is able to be modified if people agree they'd rather do something a little bit different (e.g., omit an activity so there is more time for discussion). And when the party (or class) is over, the host makes sure that people know their attendance was welcomed and appreciated. The warm and respectful atmosphere you created by treating class participants as guests is particularly effective as a technique for working with adult learners.

Things to Keep in Mind As You Begin Your Planning

If it happens that you, the program developer/instructor are in the beginning stages of your career, here are some tips which can save you from undue stress as you plan classes for your program.

1. Start with a few rather than a lot of classes, so there will be time to make sure all the organizational details are taken care of. Even if you have only a few class members initially, leaving them well-satisfied and speaking highly of your class to others is far better than biting off more than you can chew, then fighting an uphill battle to regain a solid reputation.

2. Make certain other instructors who participate in your classes share your belief in adult education principles and have a respect for the ability of class members to learn from each other, not just from the instructor. Strategies for capitalizing on the collective knowledge and experience of the group is described in the book, Planning, Conducting, and Evaluating Workshops, referred to earlier.

3. Begin with courses that capitalize on the instructor's strong areas, as long as those topics are ones that parents have indicated they want offered. This makes life much easier than trying to develop materials and expertise in new areas right off the bat.

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[2] Davis, Larry N., Planning, Conducting, and Evaluating Workshops: A Practitioner's Guide to Adult Education, published by Learning Concepts, Inc., 2501 North Lamar, Austin, TX 1974.

4. Use creative titles to promote classes; "Health and Safety" may be far more intriguing if it is called "Have You Ever Slipped on a Banana Peel?" as long as the subtitle or description clearly explains what the class is all about.

5. If a class focuses on one specific group, make clear for whom it is intended by including that information with your creative title or by identifying the group in the class description. Example: "Holding Heart and Hearth Together: A Class to Help Parents of Handicapped Children Cope with Multiple Demands."

6. Short classes (that meet once or twice for about two hours at a time) are generally better to start off with than a series of sessions on a certain topic; especially at the beginning of a program, it is easier for people to make a short-term time commitment.

7. Hold classes in a neutral location; some people may have negative associations with classes held at a welfare department or school administration location.

8. Choose class locations readily accessible to target group(s); this may mean decentralizing service to two or more locations, or it could mean rotating class locations.

9. Schedule classes at times people have indicated they are free to attend; make sure they are at an affordable cost. If the program must charge a fee, make certain no one will be turned away because of inability to pay.

10. Unless people expressed a strong preference for credit when you gathered your needs assessment information, leave the arrangement of "linkages" that would allow you to grant college credits or Continuing Education Credits (CEUs) until later.

11. Plan your evaluation system so participants can respond anonymously. That way feedback is more likely to be honest and open. Use the information to determine whether parent needs and your goals are being met, and to plan future services.

12. If you have a limited budget, share the bibliography for your class with your local public library and ask them to locate and/or purchase specific books.

13. When assessment data indicate more needs than your program can accommodate, look into the possibilities of other community agencies contributing to the planning and/or delivery of service.

Tips to help one survive the actual class meeting include:

1. Set a comfortable "stage" with a welcoming, warm atmosphere. People are much more likely to return if they remember a comfortable place rather than rows of chairs in a bare church basement.

2. A warm coffee pot is a terrific ice-breaker.

3. Provide name tags to help people know each other.

4. Chairs arranged in circular formation encourage participation.

5. Begin the first sessions with an introduction of yourself and ask class participants to do likewise.

6. Share the bibliography and display appropriate books during first class session. Let class members know about loan sources for suggested books.

7. Arouse the participants' curiosity, stimulate their imagination, and capture their interest with your opening statement or question.

8. Structure a logical presentation using coherent, interesting facts illustrated with concrete examples. Summarization at ending points reinforces learning.

9. Plan the right amount of materials for the time available. (This will be difficult at first.)

10. Clearly explain any technical terms.

11. During a discussion: begin with a well-formulated question, help class participants remember the topic of discussion, clarify by rephrasing, and summarize when necessary.

12. When appropriate have an infant or toddler present during part of the session for demonstration.

13. Always preview a film to develop an introduction to the film and to formulate discussion questions.

14. Talk with a guest speaker in advance of the class meeting to acquaint the speaker with group/class objectives, to develop an introduction to the presentation, and to formulate follow-up activities.

15. Respect the participants' values and attitudes, but also offer alternative points of view in a non-threatening manner.

16. You can't know everything. If a class participant asks a question and you don't know the answer, admit it and promise to find the answer by the next session. Then follow through!

17. If the class meets during a mealtime, arrange for a box lunch or suggest participants bring a brown bag, so that your time goes into class planning and presentation, not food planning.

DESIGNING THE FRAMEWORK: NEEDS ASSESSMENT*

An important part of planning the kind of service which will have an impact in your community is assessing whether there is actually a need for that service. If you have determined that there is a need, you can be reasonably assured that there will be people needing and wanting the program service that results from your planning effort. To identify need, you will probably conduct a needs assessment, either formally or informally. A NEEDS ASSESSMENT IS ESSENTIALLY A SURVEY OF YOUR COMMUNITY AT LARGE, OR OF PARTICULAR GROUPS WITHIN YOUR COMMUNITY, TO DETERMINE WHAT SERVICES OR ASSISTANCE PEOPLE NEED OR WANT.

Your interest in offering infant-toddler classes or workshops probably developed as a result of your own observation and investigation. You came to believe that parents in your area are interested in improving their parenting skills. Actual feedback from these people and others concerned about children will provide a basis for setting program objectives. If your initial reading of the community need has been accurate, the feedback will validate it. Input from the community will also let you know which needs people are actually ready to address.

Don't be surprised if the need you see as most important is not ranked first by the community at large. It doesn't necessarily mean you misjudged the existence of the need. It may mean the community is not yet ready to work on that issue. It is possible to plan successful educational programs in situations where the needs the community would like addressed differ from the priorities of the program developer. For more information on this subject, refer to the chapter on "Constructing the Content: Classes".

The information you gain from your assessment of community need will also aid you in evaluating your program. It directly affects the goals you set for the program, goals which will be measured against outcomes later on.

Though a procedure to follow in conducting a needs assessment will be suggested here, the procedure is not as important as the results. What you should get from your needs assessment is:

1) a clear picture of community, group, or individual needs which you can translate into a workable educational program for parents, and

2) community involvement in the needs assessment process, with general agreement about the proposed program.

A process for accomplishing a needs assessment has been suggested in the booklet, "A Guide to Needs Assessment in Community Education."* Though this process will not apply equally to all readers, it has been adapted and condensed here for those who would like an overview of a needs assessment sequence. Because a needs assessment committee, or a subcommittee of the advisory board often takes responsibility for a needs assessment, you will find reference to such a group throughout the following steps.

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*Available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

Step 1. Identifying People and Roles. People make a needs assessment happen. The first step is to identify exactly who is responsible for the needs assessment, and what role each of those people will play.

Step 2. Stating Concerns and Goals. Before the needs assessment committee collects data, they state their areas of concern and write a needs assessment goal to go with each one. Example: Area of concern--teenage parenthood. Needs assessment goal--to assess 1) options and 2) interest in the community for supporting and educating teenage parents.

Step 3. Finding the Needs. This step determines the discrepancy between community needs and the services and programs available to meet them. The needs assessment committee checks their perception of what is needed with data from the community, i.e., information from agencies/organizations, and from community residents.

Step 4. Reassessing and Prioritizing Needs. Based on needs assessment information collected from community organizations, agencies, and residents, the committee reassesses the initial goals which were defined. They then prioritize those goals by weighing the amount of time and resources needed to satisfy them, and the importance of each goal according to community perception.

Step 5. Determining the Feasibility of Meeting the Needs. With priorities set, the feasibility of each is examined. This means taking stock of existing and potential resources, and possible limitations. Careful review might result in a re-ordering of priorities. The committee might decide to begin with some lower priority goals to insure initial success and to get the community involved before going on to the higher priorities.

Step 6. Planning the Program (Objectives and Procedures). When priorities are agreed upon, objectives can be set for the year. Objectives provide the link between needs assessment, the program plan, and the evaluation process. They are written so they can be documented, either by objective data (like the numbers of people who participate in the program), or by subjective measures (like a log with observations of program impact on individuals, groups, or the community; or personal quotes from participants).

Step 7. Continuous Reassessment. Because the needs of people in a community will keep changing, along with their interests and skill levels, assessing need is an ongoing process. Whether it is accomplished on a more or less formal basis, it is an integral part of the cycle of planning, implementing, and evaluating service.

These seven steps describe the full spectrum of the needs assessment process. The nitty gritty of actually finding the needs, discussed in step three above, raises the question of "how to do it?" Some "how-to" decisions are addressed in the following section.

Method of Data Collection

Just as communities and the people who live in them differ from place to place, so needs assessment methods will differ from one progrm to the next. The most commonly used methods of collecting needs assessment data are:

- input from a representative group (advisory board, planning committee, task force)

- surveys of agencies, particularly human service

- surveys of citizens

  a. interview (telephone or face-to-face)

  b. mail-out surveys (see samples beginning on p.21 and p.27).

  c. community gatherings (attending community meetings or calling a town meeting)

Input from a representative group. Having your entire community involved in your needs assessment would be ideal, but it is also usually impossible. A more practical and frequently used approach to involving the community is to form an advisory group or task force which is representative of a broad range of groups, organizations, and individuals in the community. This advisory group is frequently an integral part of the entire program from planning and implementation to evaluation and reassessment. Assisting with the needs assessment is just one of the many tasks such a group can undertake.

In some cases an initial needs assessment may simply be made up of input from this group, based on their knowledge of the needs and interests of the constituents they represent. The needs of the community are added when services are underway and program participants are polled directly. In other cases, the advisory board (or a subcommittee of it) goes beyond acting as spokespersons for the community and takes responsibility for actually planning and carrying out a more direct survey of the community needs during the planning stages of program services.

A community in Minnesota which used the "representative group" approach to gathering needs assessment formed a group by drawing from social service, health, and education agencies. They were responsible for program planning, including providing information about community needs. They shared their perceptions of training needs, based on information from the various groups with which each worked. They went beyond assessing needs to choosing a target audience for initial service, setting goals, and deciding that a workshop format was the most feasible way to deliver service. The advisory board members checked their perceptions of need with the actual community need by talking with parents who were their constituents. They personally invited parents to the first workshops. At the workshops, more needs assessment data was collected by having the participants fill out forms. This information was used to plan additional program services.

Surveys of agencies. Another method of collecting data on community needs is for you, the program developer/instructor, or members of your advisory committee, to interview representatives of agencies in your area. A questionnaire is a good way to guide your questions and record people's responses. From a needs assessment point of view, your aim would be to find gaps in existing community programs which your program could fill. But as you are gathering information, you can also be gaining support for your program plans by establishing a basis for cooperative relationships with the community agencies you are contacting. From this, referrals to your program can result, or co-sponsorship of projects later on plus increased community awareness of your program services as personnel from other agencies help advertise your plans.

Surveys of citizens. Getting information directly from residents of a community is an effective way to hear "straight from the horses' mouth" what people want. It also provides an opportunity for the creative program developer/instructor to raise awarness of and stimulate interest in the upcoming program. One of the goals of a good needs assessment is to get your community involved in the process, and surveying citizens directly is an excellent way to accomplish that goal. In addition, when people are asked for their input they are likely to feel they had a role in shaping the new program, which means they tend to have a greater investment in the outcome.

These are the three methods which are frequently used to survey the citizens of a community:

- interviews
- mailout surveys
- community gatherings

The first of these, interviews, can either be conducted face-to-face or on the telephone. The face-to-face interview is usually done door-to-door using a questionnaire designed in advance. A representative sample of residences and businesses is selected to be contacted. The "man-on-the-street" method, another form of face-to-face interview, also requires a questionnaire, plus careful planning for a proper time and place to conduct the survey.

Advantages to the face-to-face interview are:

1) more insight into problems and needs because questions can be clarified and responses are more free-flowing

2) the highest percentage of responses per individual surveyed

Disadvantages to the face-to-face interview are:

1) more expensive method of data collection

2) need for training interviewers

3) results can be subjective due to interviewers' biases

4) personality clashes can develop between interviewer and person being surveyed

The second type of interview used to survey community residents, the telephone interview, again requires a questionnaire, plus a selection of representative numbers to be called.

The advantages to the telephone interview are:

1) that it is less threatening than a door-to-door contact

2) it has the ability to reach a relatively large part of the community at less cost than the face-to-face interview

Disadvantages to the telephone interview are:

1) the expense

2) unlisted telephone numbers or homes with no phones

3) the need for training interviewers

In one community a creative adaptation of the usual telephone survey was thought up by program developers. They wrote 30-second and 60-second radio spots to be broadcast during the summer, prior to the first offerings of classes which were to begin the following fall. The radio spots had a twofold purpose, to add to the public's information about child development and family life, and to create interest in the upcoming program offerings. As a result of the media blitz, their planning group received many calls from people expressing their agreement with the program plans and stating their interest in becoming involved. People in the community were making a clear statement of need by responding enthusiastically to the media appeal.

Yet another method of surveying community residents is the mail-out survey. This involves developing a questionnnaire and getting hold of addresses of a representative number of individuals in the community.

The advantages of the mail-out survey are:

1) low cost

2) the chance of more honest answers because responses can be anonymous

3) its practicality in rural areas

The disadvantages of the mail-out survey are:

1) usually poor response rate (under 25%)

2) difficulty getting representative addresses

3) lack of response from people who have difficulty reading

4) responses to questions are less open-ended than with the face-to-face interview

The final method of polling citizens of a community is through the community gathering. You, the program developer/instructor, can either go to the community, or ask that the community come to you. If you go to the community, you request to be included on the agenda of meetings like those of the Mrs. Jaycees, Rotary Club, Chamber of Commerce, church groups, or American Association of University Women, to name a few.

If you plan to ask that the community come to you, you are essentially planning a town meeting or forum (in some circles this is referred to as a "hearing.") This involves notification of the purpose of the meeting in the local newspaper, with an invitation to people to attend. The comments of people at the gathering are summarized by the program developer, who in that case is acting as the needs assessor.

The advantages of getting information from either of the two forms of community gathering described above are the low cost, and the quickness with which it can be done. At a town meeting or forum, however, there may be difficulty getting

a representative group of people. There is also the possibility of having insufficient time for everyone to express themselves. In addition some people might feel intimidated about expressing their views publicly.

Given the consideration it deserves, the needs assessment process will help you define service objectives, give direction to your program planning, and provide pre-service information necessary for later program evaluation. By keeping in touch with the changing needs of people who are caring for children in your community, you can adjust your training services accordingly. Becoming aware of community needs, and staying in touch with them as they change, is an excellent insurance policy for program success.

PREPARING FOR YOUR AUDIENCE

RESOURCES

INTERESTS AND NEEDS OF FAMILIES WITH YOUNG CHILDREN

QUESTIONNAIRE

The purpose of this questionnaire is to determine the needs and problems of families with young children in the Duluth area, so that we can better coordinate programs and services. Your answers to the questions below will help us. You need not use your name.

Parent or person filling out survey: Mother___ Father ___ Other _____

Marital Status: Single___ Married ___ Occupation: _____

I have ____ children, whose ages are _____. Is transportation a problem in obtaining services? Never ____ Seldom ____ Sometimes ____ Always ____

Directions: Check beside each topic how interested you are in knowing more about it.

How interested are you in learning more about:	very interested	somewhat interested	not at all interested
I. HOW CHILDREN LEARN AND GROW			
1. What to expect your child to know and do at different ages.			
2. How parents can help children grow and learn.			
3. How to build children's self-confidence.			
4. How to tell if your child has a growth and development problem, and what to do about it.			
II. HEALTH AND SAFETY			
5. Planning and preparing healthful food.			
6. How to keep your child from getting hurt and how to take care of a hurt or sick child.			
7. How to keep your child well: health habits, exercise, sleep, etc.			
III. HELPING CHILDREN LEARN TO GET ALONG WITH OTHERS			
8. How to know what behavior to expect at different ages.			
9. What to do when children fight and quarrel.			

	very interested	somewhat interested	not at all interested
III. HELPING CHILDREN LEARN TO GET ALONG WITH OTHERS (CONT'D.)			
10. How to teach right from wrong.			
11. How to guide and discipline children--help them learn how to behave.			
12. How to express feelings in an acceptable way.			
IV. HELPING CHILDREN WITH SCHOOL READINESS			
13. How to select and use activities (books, games, toys, family outings) to help your child learn.			
14. How to teach children to listen and follow directions.			
15. How to help children enjoy learning.			
16. How to help children improve their language.			
17. How to teach children to think and solve problems.			
V. FAMILY LIVING			
18. How to plan your day and your family's day so things go smoothly and you have time for important things.			
19. How to locate good child care.			
20. How to meet your personal needs--for talking with other people, doing things that are fun to you, having enough energy to be a parent.			
21. Getting along in the family: television, bedtime, meals, sharing, and taking turns.			
22. How to show love, affection and concern in the family.			

VI. LEARNING ABOUT THE WORLD

	very interested	somewhat interested	not at all interested
23. Telling your child about sex, death, divorce, and other things we find difficult to discuss.			
24. How to teach your children about their own and other cultures and people.			
25. Explaining the world in a way that children can understand--such as the natural world, things they see on television, etc.			

Some other things I would like to know more about are:

We all learn about parenting in different ways. How interested are you in learning more about being a parent from:

	very interested	somewhat interested	not at all interested
1. Reading books.			
2. Talking with parents in groups.			
3. Watching a special TV series			
4. Seeing movies near my home (at a school).			
5. Having a person visit my home and talk with me each week.			
6. Reading about this in magazines or newspapers.			

The following is a list of services that could be available to you in your neighborhood. Check beside each service whether or not you would be interested in participating.

	YES, I would probably participate	NO, I would not participate	I might participate; not sure
1. Pre-natal classes.			
2. Pre-school program for your child at a center for part of a day, 1 or 2 days a week.			
3. Full-time day care arrangements for your child.			

	YES, I would probably participate	NO, I would not participate	I might participate; not sure
4. A weekly session for parents and children, where parents meet together to discuss common concerns, while children are having a pre-school experience.			
5. After-school care for school-aged child.			
6. Occasional movies or speakers dealing with family concerns.			

Other services I would like to have available for my family are:

We are interested in knowing what is important to you when making child care arrangements. Check beside each statement how important it is.

	very important	somewhat important	not important
1. Convenience of location.			
2. Transportation available.			
3. Activities for child.			
4. Cost of program.			
5. Quality of care.			
6. Hours.			
7. Qualification of teachers.			
8. Time of year.			

If you had your choice of the ideal child care arrangement for you and your child, what would it be?

We thank you very much for taking the time to fill out this survey. You have helped us in being able to more closely match the services we can provide to the needs of families in Duluth. Please return this survey in the enclosed stamped envelope as soon as possible.

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A PLANNING QUESTIONNAIRE

Being a parent is one of the most important jobs anyone of us undertakes in life. Training and updating sessions are readily available for most other kinds of jobs but until recently parents have had few resources or learning options from which to choose.

Midtown Technical Center, working with its Advisory Committee for Parenting Education, would like to offer classes/workshops which would be of interest to parents and caregivers of infants and toddlers in the surrounding community. Please help us with the planning process by completing this questionnaire.

1. Which of the following would you like to learn more about: (Put double checks ✓✓ on the three most appealing topics.)

___ Knowing what to expect from infants and toddlers at different ages.

___ Understanding language and intellectual development.

___ Making fun toys out of household castoff materials.

___ Feeding the baby right.

___ First Aid for parents of infants and toddlers.

___ New baby, new ways of surviving.

___ On working out of the home and parenting an infant or toddler.

___ Can you spoil a baby?

Would like to see classes/workshops on:

___ _____

___ _____

___ _____

___ _____

2. Would you be able to find transportation to a class if it were held in:

___ North Branch ___ Pine City ___ Mora ___ Cambridge ___ Other location

Suggestion: _____

3. Would some times of the year be better than others for attending classes, workshops, etc." If so, please explain.

_____

4. Check the times and days of the week that would be most convenient for you to attend classes, workshops, etc.

Mondays	Tuesdays	Wednesdays	Thursdays	Saturdays
___ Morning	___ Morning	___ Morning	___ Morning	___ Morning
___ Afternoon	___ Afternoon	___ Afternoon	___ Afternoon	___ Afternoon
___ Evening	___ Evening	___ Evening	___ Evening	___ Evening

5. If child care could be provided during classes, would your preference for class times and days change from what you listed above? If so, please explain.

_____

_____

6. Would you be most likely to sign up for a class that:

___ meets two hours at a time for six sessions.

___ meets two hours at a time for three sessions.

___ prefer to sign up for each sesssion individually.

___ Other preference: _____

7. Do you have a special talent or skill you would be willing to share with others?

_____

_____

8. Would you like to help plan and/or advertise the classes? _____

9. Other comments or suggestions: _____

_____

_____

- -

(Optional)

Name _____ Phone _____ home

Address _____ _____ work

_____

FINDING RESOURCES TO ENRICH THE CURRICULUM

After reading through the curriculum guide, review the suggestions below and then make a chart for yourself (next page) listing all the local resources you know of, can find in the phone book or that you can learn about from your peers that might be helpful in structuring your classes or workshops.

NOTE: x - indicates possible resource for instructor

\+ - indicates possible resource that the instructor may refer a class participant to in case of an individual need or problem which goes beyond the scope of this training (see Family Issues)

Resource	Guest Speaker	AV Materials	Pamphlets	Books
State Department of Health		x	x	
State Department of Education		x	x	
Local colleges/universities	x	x		
Area technical institutes	x	x		
Head Start programs	x +	x		
Libraries		x	x	x
City Nursing Service	x +	x	x	
County Nursing Service	x +		x	
American Red Cross	x	x	x	
American Heart Association	x	x	x	
American Lung Association	x	x	x	
National Dairy Council	x	x	x	
MN Council on Quality Education	x +	x		x
PET (Parent Effectiveness Training)	x +			
Adler Institute	x +			x
Family Life Education Centers	x +			x
Marriage Encounter	x +			
MN Couple Communication Program	x +			
Emotions Anonymous	x +			
Parents Anonymous	x +			
Alcoholics Anonymous	x +			
Al-Anon	x +			
Family and Childrens Services	x +			
Child Protection Service	x	x	x	
Poison Control Center	x	x	x	
March of Dimes	x		x	x

Local Resources

Name (Person or Agency)	Address	Telephone	Topic Area

MID-CLASS/WORKSHOP EVALUATION

Class Title _____

Date _____

Instructor _____

In order to ensure that this class will be the learning experience you had hoped for, I am requesting that you take a few moments to fill in this mid-class evaluation. Your honest feedback will enable me to make appropriate adjustments, where and when possible, when planning the remaining sessions.

1. Circle activities which have been most useful to you:

   Lecture, Demonstrations, Viewing films/filmstrips, Group Discussions, Doing projects, Others: _____

   Which activity has been the least useful? _____

   _____

   Why? _____

   _____

2. In my opinion the instructor (check the most appropriate responses)

___ Is well organized and well prepared for class.
___ Is sometimes well organized and well prepared for class.
___ Is seldom well organized and well prepared for class.

___ Listens and responds appropriately to class members' questions and concerns.
___ Does not listen and respond enough to class members' questions and concerns.
___ Almost never listens or responds to class members' questions and concerns.

___ Seems to be very knowledgeable about subject area.
___ Is somewhat knowledgeable about subject area.
___ Is not knowledgeable about subject area.

3. How have you used information presented to date? _____

   _____

   _____

   _____

Mid-Class Evaluation

4. What changes would you suggest for the remaining class sessions?

_____

_____

_____

_____

5. Other comments:

_____

_____

_____

_____

Note to instructor: On the remainder of this space insert some specific questions on content presented. This will provide feedback on your teaching effectiveness and materials.

CLASS/WORKSHOP EVALUATION

CLASS TITLE_____

DATE_____

INSTRUCTOR_____

I. In this evaluation we would like to find out which parts of the class provided the most useful and interesting information for you as a parent. Fill in answers only to those questions which apply to this class/workshop.

Please circle the number which best describes your feelings about the following:	To a great extent		Somewhat		Not at all
Lecture by the instructor was interesting	1	2	3	4	5
Class discussion was interesting	1	2	3	4	5
Watching audio-visual materials was interesting	1	2	3	4	5
Small group discussion was interesting	1	2	3	4	5
Listening to other's reports/ projects was interesting	1	2	3	4	5
Doing your own projects/reports or assignments was interesting	1	2	3	4	5
Reading materials/handouts was interesting	1	2	3	4	5
I felt the instructor					
a) Clearly presented the subject matter	1	2	3	4	5
b) Involved me in the workshop	1	2	3	4	5
c) Increased my interest in the subject	1	2	3	4	5
d) Used the time allotted for the session effectively	1	2	3	4	5
e) Raised challenging questions	1	2	3	4	5
f) Interacted well with participants	1	2	3	4	5
g) Made me feel at ease	1	2	3	4	5

CLASS/WORKSHOP EVALUATION
PAGE TWO

II. Please complete the following:

I learned _____

_____

_____

_____

_____

I would still like to know _____

_____

_____

_____

_____

If I were in charge of this session, I would change it by _____

_____

_____

_____

_____

III. Other Comments:

PREPARING FOR YOUR AUDIENCE: BIBLIOGRAPHY

Davis, Larry N. Planning, Conducting and Evaluating Workshops: A Practitioner's Guide to Adult Education. Learning Concepts, Inc., 2501 North Lamar, Austin, Texas, 1974. A practical aid for adult educators with limited preparation for this role as well as a useful reference providing new insights for those who are experienced adult educators. It is organized into (1) an introduction which provides an overview of adult learning theory along with the author's own version of the same; (2) "Planning the Workshops," eight chapters covering everything from assessing needs to packing; (3) "Conducting the Workshop," five chapters dealing with the nitty gritty of presenting the material such as setting up, creating a learning climate, agreeing on objectives, directing learning activites and closing shop; and (4) "Evaluating the Workshop." The author set out to create "a basic, concise and complete guide to the theory and practice of adult education," and he has met this objective through this book.

McLagan, Patricia A. Helping Others Learn: Designing Programs for Adults. Addison-Wesley Publishing Co., Reading, Mass., 1978. This is a practical guide to help educators incorporate ways to help learners process information effectively. It suggests practical ideas and techniques that assist in the motivation, learning and application of course material. Clear concise text, enhanced by visual organizers further its usefulness. It promotes the notion that the most successful learning takes place when the learners share responsibility for their own learning.

Middleton, Susan. Blueprints: Building Educational Programs for People Who Care for Children. Toys 'n Things Press, St. Paul, 1981. A how-to handbook for people who are building new programs or expanding existing ones. The handbook covers public relations techniques to classes, resources, and evaluation. General information is made specific with examples from the beginnings of seven Minnesota programs for parents and day care personnel.

Family Issues

AN INTRODUCTION FOR THE INSTRUCTOR

Many parent educators have found that parents often have personal needs which, to some degree, overwhelm and distract them from concentrating on their parenting role. Attempts to "educate" parents on topics such as normal growth and development of infants and toddlers, good nutrition for babies, etc., become exercises in futility if the parents' personal needs are left unmet.

To clear the way for an optimal learning experience, it is often wise to offer an opportunity for the class participants to get in touch with their own feelings and needs at the onset of the class. Participants should be encouraged to share frustrations and concerns, and to learn some techniques that will enable them to solve their problems and/or diffuse their sense of need. Participants should also be encouraged to feel comfortable using the instructor and the other class members as supportive resources if problems come up during the course.

The unit on Family Issues is designed to serve as a guide and resource for the instructor to initiate the process of helping parents deal with many of the issues which often stand in the way of their own growth and development. The unit is by no means all inclusive. The instructor is encouraged to add or delete topic areas based on the assessed needs of individual groups.

If group members are hesitant to express needs initially, the instructor may simply let them know that he or she is willing to discuss family issues, mentioning the topic areas. The instructor will also need to build the kind of flexibility into the class schedule which will allow for dealing with such issues, when appropriate.

The instructor will find reference to instructor resources and participant handouts in the "Resources" column. There are, however, additional films, filmstrips, pamphlets and books listed in the resource section beginning on p.55. The instructor should use these and seek out others to enrich the curriculum either as supplementary information for self, or to be shared with the class participants.

TEACHING OUTLINE

FAMILY SYSTEMS

CONTENT	INSTRUCTOR-PARTICIPANT INTERACTIONS	RESOURCES
Family is . . . . Family, according to Webster: 1: A group of persons of common ancestry. Clan 2: A group of individuals living under one roof and under one head. Household 3: A group of things having common characteristics or properties. 4: A social group composed of one or two parents and their children.	Ask participants what their notion or definition of family is. Come to a consensus of what family is.	Discussions on the topic of healthy families can be found in Family Development, Feb 1980, by Ronald L. Pitzer, Home Extension Division, University of Minnesota, and/or in Building Family Strengths: Blueprints for Action, "In Search of Strong Families" see Bib. p. 84.
Healthy Family Systems From the limited empirical data gathered on "healthy families" the following characteristics are found to be held in common by families who are seen as "strong" or "healthy." 1. The members of strong families frequently and spontaneously show support, respect, affection, and appreciation for each other, behaving as allies, not competitors. 2. In the strong families, there is an awareness, an acceptance, a valuing, even a celebration of individual uniquenesses and differences and an absence of rigidity, dominance, and strict hierarchy in family relationships.	Discuss the fact that families may be unique as to composition, number of members, individual talents, how they problem-solve, the value they place on material goods, education, work, play, children and in many other aspects. Share and discuss with class participants the characteristics of "strong" or "healthy" families. Have them suggest other characteristics they feel contribute to healthy relationships within the family. Stress that there are degrees of this type of "well-being" within most families. Also, mention that together the class will explore factors that contribute to "unhealthy" families often resulting	

CONTENT	INSTRUCTOR-PARTICIPANT INTERACTIONS	RESOURCES
3. The strong families are flexible in making adjustments and open to change. 4. The strong families communicate easily and well, facing conflicts openly and trying to solve them. 5. The strong families have a high degree of unity, and share commonly recognized values and goals. 6. The strong families are characterized by a strong commitment of the members to one another and they do a lot of things together. 7. The strong families have connections with other families and the community.	in child abuse, and some ways that everyone can consciously promote the well-being within their own families.	
The Unhealthy Family Note: For the purpose of this curriculum "the unhealthy family" system will be discussed in terms of families who are victims of child abuse and neglect. Keep in mind that as instructors use this curriculum they help parents avoid many of the pitfalls of becoming neglectful or abusive by: (1) helping participants gain a good understanding of normal growth and development; (2) facilitating learning and sharing within the group in ways that allow informal, non-threatening support systems to form; (3) referring participants who indicate a need for further support or counseling to special resources within the community, e.g., Parents Anonymous; (4) using this unit to make participants aware of their power to effect positive changes in their lives.		
Characteristics/Factors that Contribute to Abuse and Neglect in Families Adult who may have had negative childhood experiences, has low self-esteem,	Discuss the fact that we all have the potential to be child abusers. Ask the participants to brainstorm some of the factors which may cause	See Instructor Resource "A Model for Understanding Abuse and Neglect," p. 57.

CONTENT	INSTRUCTOR-PARTICIPANT INTERACTIONS	RESOURCES
expresses unmet dependency needs as pseudo-independence, denies own feelings, has learned not to trust and isolates self, seeks mate to form psychological couple modeled after own abusive parents, covers a fear of losing control with rage, turns to infant or small child for own nurturing, has learned extreme disciplinary practices, is confused and frustrated by contradictory child development information, misinterprets child's "normal" behavior, has psychopathic/psychiatric disorders, has problems with discipline.	a parent to abuse a child. List their ideas on the board or flip chart, add characteristics listed at left, expand on the meaning/implications of each.	
Additional Factors that May Increase Potential for Abuse		
Adult who is unable to work under pressure; lacks information,on supervision or training on disciplinary techniques on how to deal with a demanding child; has unrealistic expectations of themselves or their child; feels pressure to succeed as a "good parent;" sees self as a "rescuer" to the child; is unable to handle own anger; is unable to cope with "situational" factors.		
Child who has a central nervous system dysfunction, or neurological deficits, whose gestation period or birth was difficult, is a cause of anger or disappointment, is associated with someone parent dislikes, was not available to mother in order for normal bonding attachment process to take place soon after,	Discuss the fact that it is now generally agreed among most early child development researchers that the infant is born with the ability to influence/direct the parent child symbiotic relationship so essential for the child's healthy development. There are circumstances, however, (as discussed in content column) which can interfer with this process and,	

CONTENT	INSTRUCTOR-PARTICIPANT INTERACTIONS	RESOURCES
does not match parent's expectation of baby, is in a developmental stage difficult for parent to handle, is seen as an extension of the parents' own low self-image, is seen as the parent's only chance to show some worth, is perceived as, too demanding, smart, dull, the wrong sex, different, who in order to get attention consciously or unconsciously provoke anger, irritation, or physical trauma.	unless appropriate intervention is available, child neglect or abuse may result. Have participants discuss how parents/society might intervene in these potential trouble spots. Note: This section may be incorporated with the Getting in Touch with "Parenting Feelings," p. 46 or vice versa.	
<u>Implications of Being Aware of Characteristics that Lead to Troubled Families</u> Encourages parents to: - Look at own role models (usually parents, but may mean aunts, uncles, grandmother, foster parents or others) - Review own child development knowledge. - Review own perceived limitations. - Review own self-concepts. - Review own circumstances, e.g., handling of high pressure job, expectation of self to be a super-parent, parenting a special needs child, etc., in relation to how these issues influence their parenting responsibilities.	Suggest that each participant think through how they might use the information on characteristics of healthy families to their advantage as they set forth as part of a new family system. (The addition of a baby, automatically creates a new family system.)	

CONTENT	INSTRUCTOR-PARTICIPANT INTERACTIONS	RESOURCES
The Power of the Role Model, Seen in Perspective - Abusive parents, invariably, were abused. - Not everyone who was abused, however, is an abuser.	Brainstorm how some parents, who were themselves abused manage to avoid repeating the cycle, e.g., they made a concious effort/decision not to make their children suffer as they did; they learned to communicate feelings, to have realistic expectations for children, to use healthy disciplinary methods, to seek emotional support; most importantly they learned to find and use community resources.	
Maintaining a Healthy Balance Family Systems. One way of gaining insight into one's family is to look at the three major characteristics of systems which are: 1. All parts of a system are interrelated. 2. Systems are equilibrium-seeking. 3. Systems are adaptive.	Share with the participants the handout "Family Systems" and discuss. Prepare to make a "Family Systems Mobile." Have on hand sufficient materials so that each participant or family grouping of participants can build a mobile to represent his/her or their family. Begin with two pieces and then add a third piece, making the necessary compensations to achieve the kind of balance that they would like. The major point here should be to go through the process of establishing a new balance with some sense of intentionality rather than having things happen by chance. Encourage them to take a mobile home for the baby to enjoy and as a visual reminder for them to show the control they have in determining what sort of family they wish to be.	See Instructor Resource/ Participant Handout "Family Systems: p. , and "Making a Family Systems Mobile" p. 63.

CONTENT	INSTRUCTOR-PARTICIPANT INTERACTIONS	RESOURCES
Easing the Transitions One of the major factors that causes imbalance in the family system is change/transitions. It helps to right this imbalance by being aware of the following points:		
1. The more one knows about the new role(s) the easier the transition will be .	Have the participants brainstorm how the ongoing transitions within parenthood roles might be eased. Such as, 1. Observe other parents. 2. Talk with other parents of different age children. 3. Read/take courses.	
2. The more clear-cut the transition, the easier it will be. For example, there was a conscious decision to have a baby at this particular time.	Have participants suggest reasons that would validate this statement. Some of their examples might be: 1. For financial reasons (afford to take off work, buy baby clothes, etc.) 2. Ready to make the time commitment (time to paint the nursery, finish the yard, finish school, stay home and nurse baby). 3. Is able to plan on support from own parents, friends, before or after birth.	
3. Transitions will be more difficult when other major role changes are also occurring, such as moving, starting/leaving a job. These are not always within a person's control and	Discuss other types of role changes that participants have experienced. Note: The instructor might find that some participants' have feelings of guilt caused by inability to cope with such circumstances in the	

CONTENT	INSTRUCTOR-PARTICIPANT INTERACTIONS	RESOURCES
should be avoided, if possible, around the expected event of a birth.	past. Being able to discuss it might provide a sense of relief that "it wasn't just me!" and recognizing that it would have been hard for anyone.	
4. The greater the concensus/agreement about expectations, the easier the transition.	Discuss the fact that within each relationship there needs to be (1) permission given to state and clarify feelings or provision made for open communications in order to avoid problems associated with repression/denial. (2) Effort made to negotiate/set realistic expectations. And (3) consideration taken of each person's uniqueness. Give examples for each.	See Instructor Resource "The Expectation Trap" p. 64.
Getting In Touch With "Parenting Feelings"		
Some exercises to:	Choose a subjective or objective approach depending on nature of class.	
1. Help parent(s) get in touch with their feelings about their baby and how it is normal for different people to have very different reactions to their baby and the birth experience.	Objective: Ask group to brainstorm all the different feelings different parents might have about their babies after baby's birth. List them on the blackboard/flip chart with heading "Parent-Related Feelings."	
	Subjective: Ask class participants to volunteer their own specific feelings about their baby after the baby's birth. List on blackboard. Feelings will range from shock at ugliness of baby to being awestruck by his/her beauty; from feeling a great surge of emotion (love) to feeling nothing; from being very comfortable handling and holding him, to being	

CONTENT	INSTRUCTOR-PARTICIPANT INTERACTIONS	RESOURCES
	scared to death to touch him, etc. Discuss with the class the normality of each person's feelings, e.g., some babies are or seem grotesque as a result of birth trauma. Sometimes we were prepared for the Gerber Baby instead of a real newborn. For some of us falling in love with our baby is an ongoing life-long process; for others it seems to happen even before the baby is born.	
2. Help fathers sort out their feelings about their new roles as parents. Mothers need to go through this exercise also, whether fathers are present in the class or not (feeling it from the father's perspective).	Present the various historical and cultural perspectives of the father role, as well as the more recent trends in fathering in our own culture. Have each person spend five minutes reflecting on how, historical, cultural societal and family influences have affected their perception of what fatherhood is or should be like. Discuss how these can cause conflicts in their present day life as parents. Continue brainstorming from #1 with new heading "Fathering-Related Feelings." Feelings elicited might be guilt, anger, or frustration, as a result of not being able to actively participate more fully in the pregnancy and birth, feeling helpless and inadequate around baby, worry about ever increasing financial responsibility, feeling unloved (all she cares about is the baby), smarting from friends remark such as "You didn't even get your seed back!" etc.	See Instructor Resource "The Father's Role in Infancy: A Re-Evaluation" p. 65. The Father: His Role in Child Development, The Father Book: Pregnancy and Beyond, see Bib., p. 84. Check the local library for additional books on 'the father'.

CONTENT	INSTRUCTOR-PARTICIPANT INTERACTIONS	RESOURCES
3. Help mothers sort out their feelings about their new role as parent. Fathers need to do this when they are present in class (feeling it from the mother's perspective).	Continue brainstorming list adding the heading "Mothering-Related Feelings." Feelings might be fatigue, worry about being a bad mother when baby cries, of being sexually unattractive to mate, not appreciated, overwhelmed by constant needs of baby, tired of people's advice, not enough support and advice, locked in, etc.	See The Mother's Book: Shared Experiences, Bib., p. 84.
4. Helping parents recognize two common parent behaviors that can affect their interaction with each other and the baby.	Share with the class that: 1. Mothers have a tendency to pre-empt the father, e.g., "here let me do that...it's too tight...you're holding him wrong." etc. This discourages the father and may prevent him from working out his own relationship with the baby. 2. Fathers have a tendency to cop out. They somehow don't hear the child crying in the middle of the night or they are suddenly busy elsewhere when the scent of soiled diapers permeates a room.	
5. Help couples sort out feelings connected with their new roles as Lover-Father-Mother. Common Love-Making Problems and Possible Solutions P-Too tired to make love. S-Take turns getting up with baby, or taking evening naps, make love in the middle of	Emphasize that the couple relationship needs nurturance and quality time just as much as the baby needs them. Begin a new list with two columns. Head list with "Adjusting to Parenthood," then head the left-hand column with "Some of the Problems" and the right-hand column with "Some Solutions." Ask everyone to first state some of their difficulties,	Instructor Resource and/or Participant Handout Adjusting to Parenthood: Making Love. Bib., p. 84.

CONTENT	INSTRUCTOR-PARTICIPANT INTERACTIONS	RESOURCES
the night, after some rest (and after night feeding to be assured of some quiet time). P-No sexual desire (usually female) caused by low estrogen level. S-Recognize the problem will correct itself in time (usually takes longer for nursing mothers). Discuss how partners can feel as relaxed as possible. What sort of touching each finds pleasurable. Explore different areas of body for sexual foreplay. Try different positions for making love. Use extra lubrication, such as KY jelly.	e.g., I'm/She's always too tired to make love. Continue listing problems until everyone (including the instructor) can think of no more, then problem-solve solutions in the right-hand column; or if participants spontaneously arrive at solutions as problems are stated fill them in as they come up. Note: If the comfort level within the group makes it difficult for them to respond to this exercise using the subjective approach, then switch to the objective approach, e.g., "For some couples it is hard to get back to a good sex life again because the mother is always too tired, but by talking about it and actively seeking a solution they kept the problem from ruining their marriage. Some have found that by taking turns getting up to get the baby at night or by taking turns catching up on sleep in the evenings or on the weekends, they were both able to stay awake long enough to enjoy each other again.	This is an excellent pamphlet which can be purchased at a low cost when ordered in large quantities (see p. 86 for description and ordering instructions). Instructor should make every effort to make these available to participants.
P-Decrease in frequency of intercourse S-Increase non-demand, non-sexual contact. (We still need the touch stimulation - to touch and be touched).	Couples need to be aware that men may consciously or unconsciously appear withdrawn or uninterested in sex because they are concerned about hurting, may think their feelings are "oversexed" (when they are really normal), causing them to feel guilty. Or, they may misinterpret the partner's need to be hugged or held as, "I want intercourse." Only through honest and open communication can couples avoid or resolve problems in connection with such feelings.	

CONTENT	INSTRUCTOR-PARTICIPANT INTE
P-Father no longer feeling wanted--mother wrapped up in baby, takes all responsibility for baby's care. S-Discuss feelings, allow for sharing in baby caretaking which will allow more time for partners to take care of each other.	
P-Difficulty in coping with breasts serving dual role of sex objects and baby's milk source. S-Find new areas for sexual foreplay--shoulders, neck, thighs, wrist, nape of neck--make love after nursing.	

ARTICIPANT INTERACTIONS	RESOURCES

Should the topic of breast versus bottle feeding become part of the discussion at any point during the Family Issues presentation, the instructor may wish to refer to Instructor Resource Participant Handout "Bottle or Breast Feeding? Deciding Which Is Best For You" p. 242.

TEACHING OUTLINE

WORK AND CHILD CARE DECISIONS

CONTENT	INSTRUCTOR-PARTICIPANT INTERACTIONS	RESOURCES
The New Parent's Working-Out-of-the-Home/In-The-Home Dilemma 1. Dealing with guilt feelings that accompany going (back) to work after birth or adoption of a baby. 2. Dealing with guilt feelings that accompany not going (back) to work after birth or adoption of a baby.	Have participants offer their views and feelings on the dilemma of whether to stay at home or go to work. Make note of any specific questions which can be dealt with later, such as "How soon can I go back to work without harming my baby?"	
3. Whether to work out of the home or not is a private and individual choice which has to be made based on each individual's understanding of self and economic need and circumstance, not on what society may seem to dictate.	Stress that not choosing what is best and in accordance with individual needs/circumstance may truly be harmful to the baby as our parenting behavior will, to a degree, be influenced by our emotional state. To help each individual strengthen their sense of choice based on their needs, not on "Aunt Virginia's" opinion, have them do the exercise "The Working-Out-of-the-Home/In-the-Home Dilemma" (Instructor Sample follows). Have each do the section which fits their circumstance and desire. (Be sensitive to those who may still not feel they have a choice, for example, mother/father wants to be home with baby, but partner says they cannot afford it, etc.). Stress the importance of being nonjudgemental when doing this exercise.	See participant handout The Working-Out-of-the-Home/In-the-Home Dilemma, p. 74.

CONTENT	INSTRUCTOR-PARTICIPANT INTERACTION	RESOURCES
Choosing Child Care From a survey cited in the September 1981 issue of "Working Mother" the following conclusion was made: "Without doubt, the search for child care is often the most harrowing of a working mother's experiences and the decision she is most likely to agonize about." In Minnesota working parents of infants and toddlers may choose to place their child(ren) in any of the following child care situations. They should be licensed to meet minimum health and safety requirements by the State of Minnesota. Day Care Centers--Provides care for groups of children divided by chronological age. Usually infants 0-12 mos., Toddlers 12 -30 mos., Preschoolers 2½ yrs. to beginning of first grade, and school-age first grade to 12 yrs. Age groupings may be more narrowly defined in largely populated centers. Parent Cooperatives--Licensed and operated like a day care center but is run and staffed mainly by parents.	Show "Choosing Child Care" filmstrip. Discuss with parents the importance of choosing the child care arrangement that seems to most closely agree with their personal philosophies. This will require that they: (1) observe a variety of child care settings in their community. (2) become familiar with the licensing standards which each child care program is required, by law, to meet. (3) check with their local Human Services Department and/or Child Care Council for a list of referrals of available child care slots, or in their local newspaper under "Child Care" in the Classified Ads. (4) after securing as many names and/or programs as possible, interview each one thoroughly, using the "Characteristics of Competent Infant Caregivers" as a guide. (5) keep in mind their infant's or toddler's need for consistancy of care so that they will seek out a caregiver who, along with the characteristics listed on the handout, promises to be available for long-time care.	See Audio-visual Resources Choosing Child Care p. 88. See Instructor Resource/ Participant Handout "Table 1. Characteristics of Competent Caregivers", p. 77. Instructor may secure Rule 2: Standards for Family Day Care, and Rule 3: Standards for Group Day Care from the State of Minnesota Department of Public Welfare.

CONTENT	INSTRUCTOR-PARTICIPANT INTERACTION	RESOURCES
Montessori Schools may be run as nursery schools or day care programs. May or may not include all age groups. Follows a specific program philosophy. Family Day Care Homes--A home where the child care provider and the home have been licensed to take care of children ages birth through age 12. The provider can usually care for no more than five children under kindergarten age, including her own, in addition to two schoolagers. Group Family Day Care Homes--A home where the child care provider has been issued a license to provide for up to but no more than 10 children at any one time and who, under certain circumstances is required to employ an assistant or a helper when certain age/number of children combinations call for it by the licensing standards.	Advise parents who are interested in a Montessori program for their child to check on whether or not they are licensed to meet minimum health and safety requirements by the State of Minnesota, since Montessori programs frequently operate independently.	
Working it Out Together Sometimes both the providers of child-care and parents are intimidated by each other, resulting in poor communications. Resolving poor communications is a vital aspect of a successful child care arrangement.	Have class participants state some of their concerns relating to placing their infant or toddler in day care. In addition, the instructor may wish to use the Sharing in the Caring supplement as a guide in the discussion. This guide raises questions that both caregivers and parents often have. It also discusses these questions in relation to the baby's development and tells how both the parent and the caregiver can support the baby's emotional growth while sharing in his care. Parents may also use it as a tool in developing clear and open communications with their provider.	See Instructor Resource/ Participant Handout Sharing in the Caring, p. 79.

CONTENT	INSTRUCTOR-PARTICIPANT INTERACTION	RESOURCES
Hints for Keeping Good Child Care Remember: --Child care workers are only human and usually respond to a kind word and being appreciated, so give him/her a pat on the back along with the check. --Child care workers work for a living too, and expect to be paid on agreed-upon pay days like anyone else. --Taking care of babies is hard work, respect the beginning and ending of the provider's work day by picking the child up on time. --Let them know about anything unusual that has happened to the baby since they last saw him/her, so they can adjust their care of him/her accordingly.	Instructor may wish to share the "Hints" or have participants brainstorm a list of ideas that will aid in keeping good child care.	Local libraries and bookstores have a number of recent books on 'how to choose day care.' Instructor may wish to review and share some of them with class participants or encourage participants, who are interested, to seek them out for themselves.
--From their experience in caring for babies, child care workers learn to recognize subtle signs about infant and toddler health and development. Occasionally they may suggest that the baby should be checked by a pediatrician or some other professional. They do this because they genuinely care about the baby, not because they wish to be meddlesome.	Help parents who use, or will be using child care, view their child's caregiver as someone who can share their responsibility of observing and recording their child's total growth and well being in order to 1. appropriately enhance the child's development and safeguard his health; and, 2. to catch any developmental lags or potential physical problems as soon as possible so that treatment can begin without delay.	

FAMILY ISSUES

RESOURCES

A MODEL FOR UNDERSTANDING ABUSE AND NEGLECT OF CHILDREN *

FACTORS IN CHILD ABUSE AND NEGLECT

One of the models for understanding child abuse and neglect establishes three interacting factors in the occurrence of most child abuse and neglect cases: 1) an individual's potential; 2) the "identified" child; and 3) the crisis. Studies have revealed the presence of these three factors to some degree in all child abuse cases.

A. AN INDIVIDUAL'S POTENTIAL

This refers to elements in an individual's background or personal characteristics which might put him/her at higher risk of becoming abusive.

The same characteristics or factors which are cited can increase anyone's potential for abuse, whether they are parents or caretakers.

While the information drawn from studies and observations of abusive parents denotes certain characteristics, it is important not to formulate stereotypes which then hinder objectivity in child abuse identification and case management. Not all parents who are unemployed and in financial straits, poor housing, shattered marriages and alcoholic difficulties abuse their children. Nor does being an upstanding devout Christian (religious) with a high IQ, stable marriage, fine home and plenty of money prevent attack on children.

It is difficult to "predict" which persons will become abusive. The information which follows should serve as "indicators" of possible abuse.

1. Own childhood experience negative

   Child abuse is, in some instances, a generational problem; some abusive parents were either physically abused or severely critized (emotionally abused) by their own parents.

2. Low self-esteem

   As a result of intense criticism, physical abuse, lack of emotional support and lack of positive feedback, abusive parents have extremely low self-esteem.

3. Pseudo-independence

   Many parents express their unmet dependency needs as pseudo-independence taking the form of "I can take care of myself perfectly well, and I don't need anyone or any help."

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*This material is adapted from the handbook entitled "Prevention of Abuse and Neglect in Out of Home Care" and is reprinted with the permission of the San Francisco Child Abuse Council, San Francisco, California.

4. Denial of feelings

As children, most abusive parents learned that their needs were unacceptable and feelings around those needs, taboo. Parents learned that feelings lead to punishment. They also fear being overwhelmed by unfamiliar feelings.

5. Isolation/Lack of trust

When abusive parents asked for help, they received none. Their needs were seldom met. They learned not to trust others and they isolate themselves from possible pain they know can be caused by others.

6. Psychological couple

Abusive parents frequently choose mates who are abusive, critical or passive, like their own parents. Oftentimes, one parent will be the active partner, who abuses the child, and one parent will be the passive one, who allows the abuse to continue.

7. Rage covering fear

Therapists have found that when parents are able to talk about what set off the abusive behavior toward their children, the most reported feeling is fear...fear of losing control or failing as a person or parent.

8. Role reversal

Role reversal is defined as "a reversal of dependency role in which parents turn to their infants and small children for nurturing and protection." In some instances, children assume the role of protector.

9. Unrealistic expectations of the child

Most parents are not sure what to expect from the arrival of a newborn. Abusive parents will often place high expectations on the child's ability to "save the marriage," "comfort and love them," "keep them company," or "solve all their problems."

10. Learned extreme disciplinary practices

Disciplinary techniques are passed down within the family structures. What can be considered "extreme" to an outsider, may be an acceptable traditional technique within a family.

11. Confusing child development information

There is much child development information which is contradictory and defines very specific behaviors for children at different developmental ages. Sometimes parents can become frustrated or feel inadequate if their children are not doing what the experts say.

12. Misinterpretation of child's "normal" behavior

Parents may interpret a perfectly normal behavior such as a child crying as a personal attack..."The baby's crying just to ruin my dinner".

13. Psychopathic/psychiatric disorders

In some cases, the parent's psychiatric, emotional and sociopathic behavior is the catalyst for abusive behavior. These parents represent a small percentage of the abusing population, and usually commit murder or sadistic acts.

14. Problems with discipline

While we can all agree on the positive value and desirability of discipline in child rearing, there are many conflicting theories about techniques for discipline. Most parents rely on instinct and disciplinary patterns they learned from their own parents. Many "experts" say spanking is absolutely necessary, while others encourage "communication" or "behavior modification" techniques. Parents must shop around to find effective and comfortable modes of discipline. One of the major causes of abuse, is over-discipline while out of control.

ADDITIONAL HIGHER "POTENTIAL" FACTORS

In addition, a parent or caretaker's potential for abuse can increase if he/she:

Is unable to work under pressure.

Lacks information, supervision or training on disciplinary techniques or how to deal with a demanding child.

Has unrealistic expectations of themselves or the children in their care.

Feels pressure to succeed as a "good parent."

Sees self as a "rescuer" to the child.

Is unable to handle own anger.

Is unable to cope with "situational" factors.

B. THE IDENTIFIED CHILD

Some of the reasons a child gets singled out for abuse are:

1. Central Nervous System Dysfunction

A baby with definite, but minimal dysfunction or delay of the nervous system function is difficult to care for. This child is usually thought to be completely normal by professionals and friends; he does not look different, has not been diagnosed or labeled, and people assume he requires no special attention. Yet, he eats poorly, chokes easily, and does not mold to the adult shoulder. He is difficult to diaper or manipulate physically and may be quite irritable, fussy and difficult to console. Alternately, he may be apathetic and quiet, giving little feedback to the parent.

2. Neurological deficits

Babies with very mild degrees of neurological immaturity or dysfunction greatly challenge the ability of the mother to love and attend them. Their symptoms resemble those mentioned in item 1.

3. Chance events affecting mother-child relationship

A difficult pregnancy, anger and disappointment at medical complication, etc. can be transferred to the child who in some way may be thought to be the cause of the problem.

4. Resembles unlike other - scapegoat for unresolved anger

If the father deserts the mother during pregnancy, the child can be mistreated because he is a constant reminder of the absent parent, and unresolved or unexpressed angry feelings for the desertion. If the mother does not like an in-law or grandparent and the child resembles that person, the child can get the brunt of the parent's dislike.

5. Disruptions in attachment

Researchers suggest that there are "claiming behaviors" of the human mother, not unlike those of other animal species, which are required for optimal attachment of mother and child. Therefore, any separations or disruptions in the bonding process can influence the mother-child relationship.

6. Mismatch of the child and parent's expectations

If the abusing parent has his/her heart set on a specific kind of child, for example, a cuddly, quiet, placid baby, and instead gets a fussy, uncuddly, screaming child, conflict will surface.

7. Developmental age of the child

While some parents will do very well with infants, they have a stressful time with three year olds. Some parents cannot handle the infancy stage, but delight when the child reaches school age.

The added stress or difficulty in caring for a specific developmental stage in a child, can contribute to the occurrence of abuse.

8. Child seen as "extension of self"

Some parents make little separation between themselves and their children. If their self-image is very low, they will project that on the child, finding fault in how the child looks or behaves.

9. Parent overinvested in child

Some parents feel so bad about themselves that they look towards the child as the only chance to remedy their own self-esteem. These parents will be overinvested in the child looking and behaving perfectly.

10. Role reversal

This occurs when the parental role is assumed by the child. If the child then expresses their own needs, they may be perceived as difficult, demanding or selfish.

11. Child too smart, too dull, wrong sex

If the child is too smart, the parent can feel threatened; if the child is too dull the parent may feel critical; if the child is the wrong sex, the parent may feel antagonism towards the child.

12. High-risk children

Certain children can be at high risk of abuse, if they are perceived as "different." Therefore, children who have actual physical defects or handicaps may elicit negative responses from the parent.

13. Child invites abuse

Some experts suggest that certain children deliberately or unconsciously provoke anger, irritation, and even physical trauma from adults. This is a controversial subject which has not received enough research attention.

A BRIEF LOOK AT FAMILY SYSTEMS

The systems perspective for looking at families has become quite popular in recent years. When asked, most people will say that they have heard the phrase Family Systems. However, when pressed many people will find it difficult to define just what that perspective is. The following information and the accompanying exercise is designed to give participants a better understanding of systems in general and hopefully some insights into their own particular family system.

The general definition of the system is a set of things, parts, or people. Of all the characteristics of systems, the following three seem to stand out. First, the parts of a system are interrelated. Each part, each member is related to every other part or member directly or indirectly, in a reciprocal (give and take) and causal (cause and effect) way. Very simply this means that if something happens to one member of a system, it effects every other member within that system. Two, systems are equilibrium seeking. This means that the relationships between the parts or members of a system are stable, that the goal of the system is balance or equilibrium. While things may happen to upset the balance, to upset the relationships within the system, system behavior is such that compensations will be made, relationships will be modified, so that balance will return. Three, systems are adaptive. This means that systems are capable of changing as a result of internal or external forces. They are responsive to external pressures for change as well as internal stresses and tensions. However, the ways in which systems respond may not always be conscious or deliberate.

The mobile is a useful analogy for describing the way systems function. Each piece in a mobile is connected through the system to every other piece. This is the interrelated characteristic of systems. A change in size or location of any one piece or the addition of a piece(s) will cause changes in the location or balance of every other piece within that system.

Regardless of the number, size, or shape of the pieces, a mobile will hang in balance. When the balance is upset for some reason, the mobile will not function properly until it has achieved equilibrium once again. This is the equilibrium seeking characteristic of systems. Relationships between the parts are stable.

A mobile like a family is adaptive, the third characteristic of systems. If a mobile gains or loses a piece, a new balance point will be established. If the connections between pieces are altered or the balancing rods bent the mobile is capable of adapting to those changes by establishing a new equilibrium. However, the resulting configuration within the mobile may not be as aesthetically pleasing, the balance point may be somewhat cockeyed, and the relationships between the parts may be greatly altered.

Written by
Rick Bell
Marriage and Family Therapist

MAKING A FAMILY SYSTEMS MOBILE

Making this mobile will serve three purposes:

1. To help us visually perceive the nature of our individual family systems and how we can intentionally activate a balance within that system when factors, such as the birth of a child, upsets the present equilibrium.

2. To provide a visual reminder of the control we, as individuals, have in determining what sort of family we wish to have.

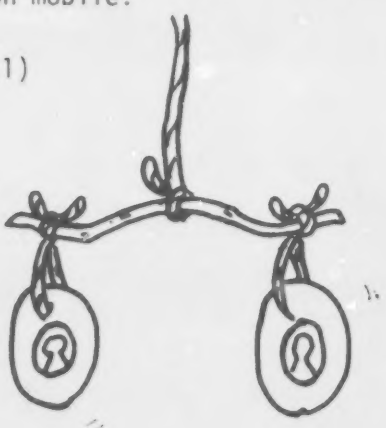
3. To provide the baby with something bright and interesting to focus on.

CONSTRUCTING THE MOBILE

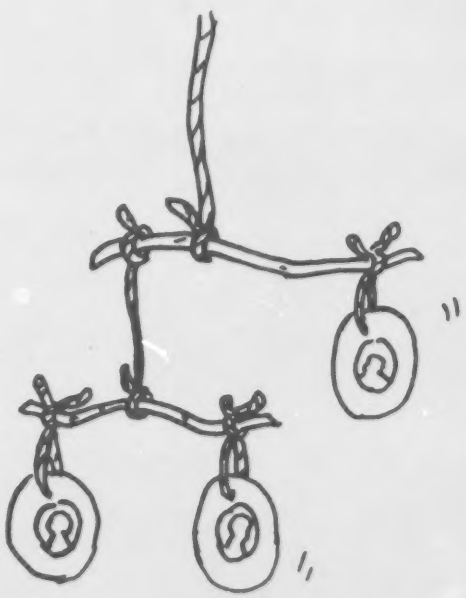
Possible items for superstructure: curtain rods, clothes hangers, wooden dowels, tree branches, heavy cardboard "donuts," etc.

Colorful and interesting items to symbolize family members, to hang on mobile: feathers, plastic fruit, wooden utensils, yarn fuzz balls, cardboard shapes, thread spools, shiny objects, drinking straw sculptures, plastic eating utensils, pictures mounted on cardboard, tinker toy sculptures , egg carton pieces, ANYTHING BOLD, BRIGHT AND LIGHT!

(1)



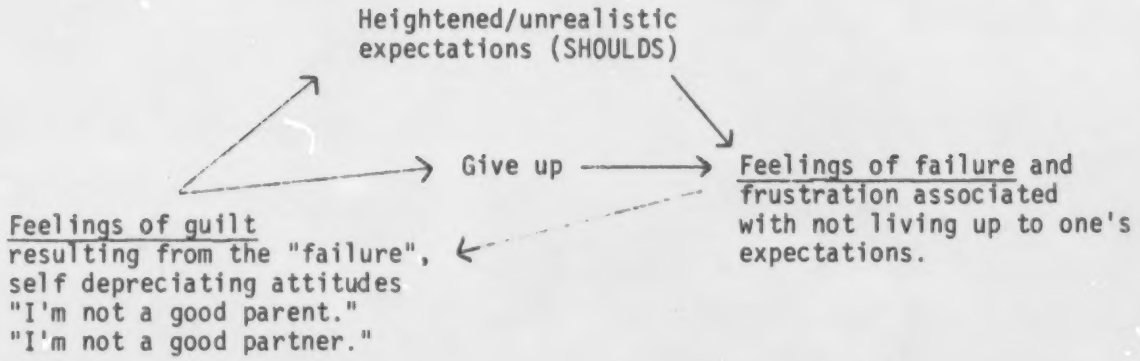
(2)



Begin your "family mobile" by first attaching to the superstructure the number of items which reflect your original family unit, then add pieces to symbolize additions to your family. With each addition rearrange all of the pieces until the most harmonious balance has been established.

Make sure objects are secure--give them a good shake to be certain.

THE EXPECTATION TRAP*


Heightened/unrealistic expectations (SHOULDS)
Give up
Feelings of failure and frustration associated with not living up to one's expectations.
Feelings of guilt resulting from the "failure", self depreciating attitudes
"I'm not a good parent."
"I'm not a good partner."

This can become a self-perpetuating cycle because we compensate for the feelings of failure and guilt by raising our expectations or by giving up.

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* Developed by Rick Bell, Marriage and Family Therapist

THE FATHER'S ROLE IN INFANCY: A RE-EVALUATION*

Ross D. Parke and Douglas B. Sawin**

The father's role in infancy is currently undergoing a major re-evaluation. Evidence from cross-cultural, historical, comparative and biological sources indicates that the father is capable of playing an active role in infant development. A series of observational studies of father-infant interaction in the newborn period were described. The results indicated that fathers are interested and involved with newborn infants and as nurturant as mothers in their interactions with their infants. While mothers spent more time than fathers in feeding and caretaking activities, fathers and mothers did not differ in their caretaking competence as indexed by their sensitivity to infant cues in the feeding situation. The implications of these findings for the father's role in infancy were discussed and the desirability of introducing greater institutional support systems for fathers was noted.

Until quite recently, there has been little consideration of the role of the father during infancy. This is the sharp contrast to the extensive research and interest in maternal roles and mother-infant interaction. The importance of the father's role in the development of older children has been indicated in a large body of research (Biller, 1971, 1974); however, it has generally been assumed that his influence begins to take on importance only in late infancy and early childhood. As Margret Mead once noted "fathers are a biological necessity, but a social accident." There are a series of propositions that can summarize our traditional views of the father's role in infancy:

(1) Fathers are uninterested in and uninvolved with newborn infants.

(2) Fathers are less nurturant toward infants than mothers.

(3) Fathers prefer non-caretaking roles and leave the caretaking up to mother.

(4) Fathers are less competent than mothers to care for newborn infants.

The purpose of this paper is to re-examine the cultural, historical, comparative and biological arguments that have given credibility to these propositions. Second, we will examine recent empirical evidence concerning the father's role in early infancy.

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Cultural and Historical Evidence

In Western, industrialized society there has been a clear set of roles prescribed for males and females, with child care being assigned almost exclusively to the mother. In fact, as Josselyn (1956) has noted, it is even considered inappropriate in our culture for fathers to be nurturant toward their infants. Nor is the attitude restricted to our own culture: an examination of a wide range of other cultures suggests a similar demarcation of roles with the mother nearly always being the primary caretaker (Lynn, 1974; Stephens, 1963). In part, this was due to the assumption that the feeding context was critical for the adequate development of social responsiveness.

Father's roles have been examined historically with the same outcome. Over a wide span of history and across a large variety of economies, the father has played a minor role in the care of infants and young children (Lynn, 1974; Biller, 1971).

However, the cultural and historical evidence is not conclusive. First, the father is not consistently assigned a secondary role in all cultures. There are exceptions in which males and females play a more equal role in the care of young children. Among the Trobianders of Melanesia, the father has considerable share in the caretaking, feeding, and transport, of young children. Similarly, in a number of other cultures including the Taira of Okinawa, the Nyansongo of Kenya, and the Ilocos of the Philippines, father and mother share more equally in infant and child care. Nor are the exceptions limited to primitive cultures as evidenced by recent trends in Sweden toward more active paternal involvement in child care.

This cross-cultural evidence brings into question the historical view of the uninvolved father as well. In fact, some have argued that the current diminished role of the father began with the "advent of the Industrial Revolution in the mid-nineteenth century." (DeFrain, Note 1).. More important than the dispute concerning the purity of the historical view of fathers is the misuse of historical arguments. It is often assumed that male and female role relations are inevitably biased by prior historical arrangements.

This position ignores the fact that secular trends which reflect shifts in technological and economic spheres can and are supporting the possibilities of new roles for males and females. As students of socialization, it is important to consistently monitor shifts in the larger social and economic structure which may, in turn, affect the definition and allocation of sex roles. In our preoccupation with the search for universal laws, too often we have ignored the fact that behavior shifts with social, economic and possibly medical developments. To cite a single example, consider the impact of bottle feeding; by a single stroke, fathers were able to overcome a biological difference which limited their participation in caretaking of young infants.

Closely related to this issue is the old distinction within psychology that needs to be brought to bear on the present context, namely the competency/performance distinction. Too often the fact of low father involvement throughout history in the caretaking of children has been extended to the conclusion that the low level of involvement was equivalent to a low level of competence.

However, the fact that historical, social and economic arrangements meant that fathers were allocated to other roles *need not necessarily imply that they are incapable of assuming a caretaking function.*

Animal and Hormonal Evidence

In addition to cultural and historical sources, evidence from the organization and behavior of animals has been examined, in part, to determine the extent to which these role demarcations are prevalent among non-human species. Typically cited are studies of non-human primates either in captivity or in the wild. For example, DeVore (1963) found that the cynocephalus baboons take little interest in infants and play a protective role for the troupe as a whole. Few instances of either play or affectionate physical contact were observed. Laboratory studies often present a similar picture. In a study from Harlow's laboratory (Chamove, Harlow & Mitchell, 1967) 20-40 day old infants were introduced to male-female pairs of preadolescent monkeys. The males and females played clearly different roles: females were four times as likely to express nurturant behavior to an infant compared to males, while the males were ten times as hostile as the females. In short, in animals as well as man, fathers appear to be less interested and involved in the care and nurturance of infants than mothers.

However, the animal literature cannot be completely relied upon to support traditional views of fatherhood. Recent animal evidence has demonstrated that males can assume a parental role vis-a-vis infants. Not only do some non-human primate species occasionally engage in nurturant caretaking of infants in the wild (Mitchell, 1969), but recent evidence suggests that male rhesus monkeys, who rarely display parental behavior in the wild, "are certainly capable of doing so when given the opportunity in the laboratory" (Mitchell, Redican & Comber, 1974, p.8). Paternal behavior, in short, can be elicited even in species that typically do not show this type of parental pattern.

There is evidence from comparative studies that "caretaking behavior" is to some extent under hormonal control. Studies with rats (Rosenblatt, 1969; Moltz, Lubin, Leon & Numan, 1970) have demonstrated that virgin females treated with female hormones show maternal behavior more rapidly than non-treated control females. The hormones associated with pregnancy and parturition are thought to "prime" the female to engage in caretaking activities.

Nor can the hormonal evidence remain unqualified. As Maccoby and Jacklin (1974) recently concluded from a review of the parenting behavior of sub-human mammals, "the hormones associated with pregnancy, childbirth and lactation are not necessary for the appearance of parental behavior. With sufficient exposure to newborns, virgin females and males will show parental behavior--although the behavior is not so readily aroused as it is in a female that has been hormonally primed" (p. 219). In short, hormones may be sufficient, but they are not necessary for the arousal or maintainance of parental responsivity.

It is clear that the animal and hormonal evidence provides only weak support for maintaining our traditional views of fathers.

Recent Observational Evidence of Father-Infant Interaction

Over the past five years, a series of observational studies have been conducted in order to describe the nature of the father's interactions with his newborn infant. In this section, we will evaluate our propositions concerning father-infant involvement in light of these empirical findings.

In the first study, Parke, O'Leary, and West (1972) observed the behavior of fathers in the family triad of mother-father and infant. One of our primary questions concerned the extent of father's interest and involvement with newborn infants. Observations took place in the mother's hospital room between 6 and 48 hours after delivery of the couple's first infant. The sample was white, middle-class and well educated. All fathers but one were present at labor and delivery and about half of the couples attended Lamaze classes. The procedure was as follows: the child was brought to the mother's room and the parents were asked, "To whom shall I give the baby?" This permitted an evaluation of who held the baby first and for how long. The family was observed for 10 minutes and a time sampling observational procedure was used. The 10 minute period was divided into 40 15-second intervals and for each interval, the observer recorded the occurrence of the following infant and parent behaviors. For the infant: cry, vocalize, move, mouth movements with or without object, look at mother, father, around. For the parents: look, smile, vocalize, hold, kiss, touch, imitate, explore, feed, hand over to other parent.

The results indicated that fathers were just as involved as mothers and that mothers and fathers did not differ on the majority of the measures. In fact, fathers tended to hold the infant more than mothers and rock the infant in their arms more than mothers. Fathers, in short, in a context where participation was voluntary, were just as involved as the mother in interaction with their infants.

However, there is a variety of questions that could be raised about this study. First, the context is unique since the mother and father were together and possibly the high degree of father-infant interaction observed was due to the supporting presence of the mother.

Moreover, the sample of fathers was unique in ways that may have contributed to their high degree of interaction with their infants. Over half of the fathers had attended Lamaze childbirth classes and with one exception, all fathers were present during the delivery of the child. Both of these factors are likely to have increased the fathers' later involvement with their infants. Finally, these fathers were well educated and middle class, and their high degree of involvement may be unique to middle-class groups; parental involvement may be less in lower-class samples due to a typically more rigid definition of parental roles among lower-class parents.

To overcome the limitations of the original study, a group of lower-class fathers who neither participated in child-birth classes nor were present during delivery were observed in two contexts: (a) alone with their infant and (b) in the presence of the mother (Parke, & O'Leary, 1976). This study permitted a much more stringent test of father-infant involvement and permitted wider generalization of the previous findings. As in the earlier study, father was a very interested and active participant. In fact, in the family triad, father

was more likely to hold the infant and visually attend to the infant than the mother. Nor is the mother's presence necessary for the father's active involvement; the father was an equally active interactor in both settings--alone and with his wife. Little support for Proposition 1 is available from these findings.

However, as Proposition 2 states, fathers may be less nurturant than mothers. A close examination of the types of activities engaged in by human mothers and fathers provides little support for this proposition. Fathers in our studies (Parke, et al., 1972; Parke & O'Leary, 1975; Parke & Sawain, Note 3) are just as nurturant as mothers. For example, in the first study, they touched, looked, vocalized, and kissed their newborn offspring just as often as mothers did. In the second study, an even more striking picture emerged--with the father exhibiting more nurturant behavior in the triadic context than the mother and an equal amount when alone with the baby. There was only a single nurturant behavior--smiling--in which the mother surpassed the father in both studies. The triadic context, however, did affect the rate of smiling; both mothers and fathers smiled more at the baby when a spouse was present than absent.

Proposition 3 states that fathers play a less active role in caretaking activities than mothers. In our early studies, the parents were free to feed the baby, but were not requested to do so. In the first study, (Parke et al., 1972) mothers did feed more than fathers--but with 18 of 19 families breast feeding, this is no great surprise. A more legitimate comparison comes from our second study (Parke & O'Leary, 1976) in which all babies were bottle fed. While fathers were more likely to feed than mother when both parents were present, fathers fed significantly *less* than mothers when they were alone with the baby.

Additional evidence comes from the third study (Parke & Sawin, Note 3) which was a detailed examination of early parent-infant interaction in a specific context --feeding. Comparison of the frequencies and durations of specific caretaking activities of mothers and fathers while alone with their infants in the more structured context indicate that mothers spend more time engaged in feeding the infant and in related caretaking activities, such as wiping the baby's face, than do fathers. Though these differences were small, they were significant and suggest some role differentiation between mothers and fathers in the feeding context during the first days of infant life. Thus, Proposition 3 receives some support from our findings.

The related and final proposition needs to be explored as well. According to this view, fathers are less competent than mothers to care for the newborn infant. How do we measure "competence?" A variety of approaches are possible, but one approach is to measure the parent's sensitivity to infant cues in the feeding context. Success in caretaking, to a large degree, is dependent on the parent's ability to correctly "read" or interpret the infant's behavior so that their own behavior can be regulated in order to achieve some interaction goal. To illustrate, in the feeding context, the aim of the parent is to facilitate the food intake of the infant; the infant, in turn, by a variety of behaviors, such as sucking, burping, coughing, provides the caretaker with feedback concerning the effectiveness and ineffectiveness of their current behavior in maintaining the food intake process. In this context, one approach to the competence issue involves an examination of the degree to which the caretaker modifies his/her behavior in response to infant cues.

Let us briefly describe how this was measured. We examined changes in the probability of occurrence of various parental behaviors in the 10-second interval following a specific infant behavior. In other words, if an infant emits a certain behavior, what happens in the next 10-second interval in terms of the parent's responses? Since behaviors occur with different frequencies throughout an interaction session, it is necessary to determine the unconditional or baseline probabilities of the occurrence of various parent behaviors. To do this, the probability that a parent behavior occurred in each of the sixty 10-second intervals of the interaction session was calculated. If there are no sequential dependencies of any behavior with the infant trigger variable, we would expect the behaviors to follow the infant trigger in proportion to their unconditional occurrence in the total data set.

The following example is an illustration. A powerful infant signal in the feeding context is an auditory distress signal, such as a cough, spit up, or sneeze. The main reaction of parents to this signal is, quite sensibly, to stop feeding and the parent does this with a conditional probability of .33. However, the unconditional probability of this parent behavior--stop feed--occurring is quite low (.05). Similarly, parents vocalize with an unconditional probability of .27, but vocalize with a probability of .45 when the infant sneezes, spits up, or coughs. In addition, the parent unconditional probability of looking closely is .12, which doubles to .25 whenever the infant spits or coughs. Touching, on the other hand, is inhibited slightly by this type of infant signal. Of particular significance are the mother-father comparisons. Mothers and fathers differ only slightly: mothers have a probability of stopping their feeding activity of .27 while fathers cease feeding with a probability (.35). Similarly, both mothers (.28) and fathers (.21) look more closely in response to this infant cue in the feeding context.

The importance of this approach becomes clear by comparing these results with the previously noted patterns yielded by both the frequency and duration indices of parental behavior. Both sets of indices yielded a picture of lesser involvement in caretaking by the father in the feeding context. However, these conditional probability results suggest a corrective to this earlier pattern. Although he may spend less time overall, he is as *sensitive as the mother to infant cues in the feeding context*.

Moreover, the amount of milk consumed by the infants with their mother and fathers was very similar (1.3 oz. vs 1.2 of mothers and fathers respectively). By further adjusting for the difference in amount of time engaged in feeding, the mothers' and fathers' amounts are nearly identical. In short, fathers and mothers are not only similar in their sensitivity, but also strikingly similar in the amount of milk that they succeed in feeding the baby.

In terms of our fourth proposition, then, our data indicate that fathers are competent in caretaking as indexed by our sensitivity of response indices.

Overall, our data indicate that:

(a) fathers are interested in newborns and, if provided with the opportunity, do become involved;
(b) fathers are just as nurturant as mothers in their interactions with newborns;

(c) fathers do apparently engage in less caretaking, but;
(d) fathers can be capable and competent in the execution of caretaking activities.

Before leaving our data, however, it should be noted that there are qualitative differences between mothers and fathers that emerge from an examination of the sex and ordinal position of the infant. Moreover, some of the differences are clearly consistent with cultural stereotypes concerning parent preferences and especially father preferences. One example will illustrate the necessity for qualification of these general patterns. In one of our studies (Parke & O'Leary, 1976), we found that fathers touched first born boys more than either later born boys or girls of either ordinal position. Fathers vocalize more to first born boys than first born girls, while they vocalized equally to later born infants irrespective of their sex. A similar finding has emerged from our sequential analyses of the impact of infant vocalizations on parent behavior. Fathers are particularly likely to react contingently to this infant cue by vocalizing--but especially in the case of the male infant. Clearly there may be some bases to the claim that fathers really do prefer boys--especially first born boys. These data are consistent with Pedersen's (Note 4) recent finding that variations in father behavior were related to the behavior of older male infants--but there was no relationship between fathering and female infants' behavior.

Caution must be exercised in generalizing from our data since all of our observations were made in the neonatal period. There is little doubt that father's role and involvement shifts with age of the infant. However, in view of the assumption that father's involvement typically comes later in the infant's development, our data take on increased significance. We are currently collecting data on father-infant interaction in the home, at three weeks and three months following discharge from the hospital in order to determine whether or not the amount and/or patterns of father-infant interaction during the newborn period are of predictive value for later behavior.

The newborn period need not be viewed as simply a starting point for observation, but as a potentially important intervention point as well. Fathers, in spite of their interest and competence, clearly need support--just as mothers need support. Moreover, it is assumed that paternal behavior can be modified, both quantitatively and qualitatively by early intervention. Mothers who were given extended contact with their infants over the first three post-delivery days, were more attached to their infants at one month, and even at one year, (Klaus & Kennell, 1970; Kennell, Jerauld, Wolfe, Chester, Kreger, McAlpine, Steffa & Claus 1974). Similarly, there is recent evidence from Sweden (Lind, Note 2) that fathers who were provided the opportunity to learn and practice basic caretaking skills during the post-partum hospital period were more involved with their infants at six months. In light of these demonstrations, it would appear that opportunities for fathers to take an active role with their newborn infants is an important antecedent to fuller actualization of nurturant and caretaking capacities in post-hospital contexts. These initial interactions with the newborn may serve as the basis for the subsequent formation of strong attachment bonds between father and infant.

The next task is to provide cultural supports for these potential activities--by modifying hospital visiting arrangements, providing paternity leaves, making available training classes so that fathers will have the opportunity to both

learn and practice caretaking skills. In turn, fathers will be more likely not only to share these responsibilities, but execute these tasks effectively and view these behaviors as role consistent. By providing this type of support, fathers will no longer be viewed as a mere "biological necessity" but be recognized as playing an important, influential and continuing role in the development of the infant.

REFERENCE NOTES

1. De Frain, T. D. Androgynous parenting. Paper presented at the International Society for the Study of Behavioral Development, Guilford, Surrey, England, 1975.

2. Lind, R. Observations after delivery of communications between mother-infant -father. Paper presented at the International Congress of Pediatrics, Buenos Aires, October, 1974.

3. Parke, R. D., & Sawin, D. B. Infant characteristics and behavior as elicitors of maternal and paternal responsibility in the newborn period. Paper presented at the Biannual meeting of the Society for Research in Child Development, Denver, April, 1975.

4. Pedersen, F. A. Mother, father and infant as an interactive system. Paper presented at the Annual Convention of the American Psychological Association, Chicago, September, 1975.

REFERENCES

Biller, H. B. *Father, child and sex role.* Lexington, Mass.: D. C. Heath, 1971

Biller, H. B. *Paternal deprivation,* Lexington, Mass.: D. C. Heath, 1974.

Chamove, A., Harlow, H. F., & Mitchell, G. D. Sex differences in the infant-directed behavior of pre-adolescent rehsus monkeys. *Child Development,* 1967, 38, 329-335.

DeVore, I. Mother-infant relations in free ranging baboons. In H. L. Rheingold (Ed.), *Maternal behavior in mammals.* New York: Wiley, 1963.

Harlow, H. F. The nature of love. *American Psychologist,* 1958, 13, 673-685.

Hosselyn, I. M. Cultural forces, motherliness, and fatherliness. *American Journal of Orthopsychiatry,* 1956, 26, 264-271.

Kennell, J. H. , Herauld, R. Wolfe, H., Chesler, D., Kreger, N. C. McAlpine, W., Steffa, M., & Klaus, M. H. Maternal behavior one year after early and extended post-partum contact. *Developmental Medicine and Child Neurology,* 1974, 16, 172-179.

Klaus, M. H., & Kennell, J. Mothers separated from their newborn infants. *Pediatric Clinics of North America,* 1970, 17, 1015.

Lynn, D. B. *The father: his role in child development.* Monterey; Brooks Cole, 1974.

Mitchell, G. D. Paternalistic behavior in primates. *Psychological Bulletin,* 1969, 71, 399-417.

Mitchell, G. D., Redican, W. K., & Gomber, J. Males can raise babies. *Psychology Today*, 1974, 7, 63-67.

Moltz, H., Lubin, M., Leon, M., & Numan, M. Hormonal induction of maternal behavior in the overiectomized rat. *Physiology and Behavior*, 1970, 5, 1373-1377.

Parke, R. D., & O'Leary, S. E. Father-mother-infant interaction in the newborn period: Some findings, some observations and some unresolved issues. In K. Riegel and J. Meacham (Eds.), *The developing individual in a changing world, Vol. II, Social and environmental issues*. The Hague: Mouton, 1976.

Parke, R. D., O'Leary, S. E. & West, S. Mother-father-newborn interaction: Effects of maternal medication, labor and sex of infant. *Proceedings of the American Psychological Association*, 1972, 85-86.

Rosenblatt, J. S. The development of maternal responsiveness in the rat. *American Journal of Orthopsychiatry*, 1969, 39, 36-56.

Stephens, H. N. *The family in cross-cultural perspective*. New York: Holt, 1963.

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INSTRUCTOR'S SAMPLE

THE WORKING-OUT-OF-THE-HOME/IN-THE-HOME DILEMMA

(An Exercise in Absolving Guilt Through Legitimate Rationalizing)

I work out of the home because...	although it makes me feel guilty,	until I realize that I needn't because...
-I like my job	-because I wonder is that like putting my job before my baby?	-when I work I'm happy and my baby deserves a happy mother/father.
-I need the money	-because I should not put money before being a full-time mother to my baby.	-working and earning <u>is</u> part of taking care of my baby.
-I'd go crazy at home all day	-because a mother is supposed to enjoy taking care of her house and family above all else	-no one would enjoy me as a mother or anything else if I should lose my mind.

I work at home because...	although it makes me feel guilty,	until I realize that I needn't because...
-I enjoy being a homebody	-because it seems like I am betraying the women's movement	-the women's movement really advocates that everyone has a choice.
-I'd go crazy trying to manage baby and work both	-because others do it so I should be able to, also	-we are all different, and I know its better for my baby and me if I make working at home my full-time commitment, at least for now.

THE WORKING-OUT-OF-THE-HOME/IN-THE-HOME DILEMMA

(An Exercise in Absolving Guilt Through Legitimate Rationalizing)

I work at home because... although it makes me feel guilty, until I realize that I needn't because...

THE WORKING-OUT-OF-THE-HOME/IN-THE-HOME DILEMMA

(An Exercise in Absolving Guild Through Legitimate Rationalizing)

I work out of the home because... although it makes me feel guilty, until I realize that I needn't because...

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TABLE 1. CHARACTERISTICS OF COMPETENT INFANT CAREGIVERS*

Desired Caregiver Characteristics	Cues to Desirable Caregiver Characteristics
I. Personality Factors	
A. Child-centered	1. Attentive and loving to infants 2. Meets infants' needs before own.
B. Self-confident	1. Relaxed and anxiety free. 2. Skilled in physical care of infants 3. Individualistic caregiving style.
C. Flexible	1. Uses different styles of caregiving to meet individual needs of infants. 2. Spontaneous and open behavior. 3. Permits increasing freedom of infant with development.
D. Sensitive	1. Understands infants' cues readily. 2. Shows empathy for infants. 3. Acts purposefully in interactions with infants.
II. Attitudes and Values	
A. Displays positive outlook on life	1. Expresses positive affect. 2. No evidence of anger, unhappiness, or depression.
B. Enjoys infants	1. Affectionate to infants. 2. Shows obvious pleasure in involvement with infants.
C. Values infants more than possessions or immaculate appearance	1. Dresses practically and appropriately. 2. Places items not for infants' use out of reach. 3. Reacts to infant destruction or messiness with equanimity. 4. Takes risks with property in order to enhance infant development.
III. Behavior	
A. Interacts appropriately with infants	1. Frequent interactions with infants. 2. Balances interaction with leaving infants alone. 3. Optimum amounts of touching, holding, smiling, and looking. 4. Responds consistently and without delay to infants; is always accessible. 5. Speaks in positive tone of voice. 6. Shows clearly that infants are loved and accepted.

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B. Facilitates development

1. Does not punish infants.
2. Plays with infants.
3. Provides stimulation with toys and objects.
4. Permits freedom to explore, including floor freedom.
5. Cooperates with infant-initiated activities and explorations.
6. Provides activities which stimulate achievement or goal orientation.
7. Acts purposefully in an educational role to teach and facilitate learning and development.

I. SHARING IN THE CARING

"a baby-parent-caregiver relationship"

Many concerns arise for both the parents and the caregivers of infants and toddlers in day care. Some of these concerns are the result of social pressures and attitudes, such as "a mother's place is in the home raising her own children" and some from a real fear that "only a parent can do what is best for the child". Following are some of the questions most commonly asked by parents and caregivers. Each question is followed by a discussion based on some of the more common understandings and thoughts on child development and behavior today. We hope that you (parent and caregiver) will find this useful in sharing your feelings and concerns with one another and that it will help you come to a clearer understanding of where the three of you (baby-parent-caregiver) "fit" in this relationship and how you can each benefit to the greatest extent.

Concern No. 1 -

Parent: *"When my baby spends so much of her "growing up" time with someone else, will she know who her real parents are?"*

Caregiver: *"If I give the baby too much attention, will I take her affections away from her parents?"*

Discussion: Both the parent and the caregiver should clearly understand that infants and toddlers must be able to build trust relationships with one or more adults in their lives in order to develop normally. This relationship is formed through consistent interactions and is most often referred to as attachment. The parent and/or caregiver who consistently responds to the baby when she cries; whether it is because she is hungry, wet, not feeling well or simply lonesome, is letting the baby know that the world is a safe and secure place. The baby learns that she has several people she can count on. These adults form a base of security from which the baby can safely strike out when she is ready to explore on her own. The special relationship between a parent and a child will not be affected as long as everyone is honestly providing for the child that which is best for her.

Concern No. 2 -

Parent: *"Will it cause my baby psychological harm throughout life if I place her in day care at such an early age?"*

Caregiver: *"Shouldn't the baby's mother really be staying home with her, after all, only the parents can provide what she really needs?"*

Discussion: Based on the limited studies done to date, good day care does not cause any long-range harmful effects on children. It is the quality of the care that counts, not whether it comes from the biological parent or not.

Concern No. 3 -

Parent: *"How will I know if she is getting the love and attention she needs when I am not with her?"*

Caregiver: *"Should I be giving the baby all the love and attention her parents would if they were with her all day, and how can I let them know what the baby's day is like here?"*

Discussion: Yes, the provider should give the baby the same attention a parent would because the baby needs consistent, continuous care. Parents and caregivers need to set up a system of clear communication which enables the caregiver to give total care to the baby and which gives the caregiver the opportunity to share the baby's day with the parent. This might be accomplished through a running log that the caregiver keeps in a notebook for the parent to read at the end of the day and which the parent fills in for the caregiver to read in the morning. Such entries as "Johnny's teeth were giving him an extra bad time today, we cuddled and rocked quite a bit" or a parent might jot down "Lisa got a little impatient with me this morning and tried to climb out of her crib, but fell out instead. She seems to be all right - but keep an eye on her, OK?" are not only reassuring to the parent, but are also helpful ways by which both parent and caregiver clue each other in on where the baby is at. Both are thus able to provide for the baby's needs on a continuous basis. This might seem like a lot of extra work, but when looked at in the light of the importance of providing good care for baby, scheduling time for keeping a log (need only take 3 minutes a day) should go right along with time for applying make-up, cleaning up the toys, etc. You may also want to set up special times ($\frac{1}{2}$ - $1\frac{1}{2}$ hour) just to chat with the parents, rather than relying on beginning or end of the day snatches of conversation.

Concern No. 4 -

Parent: *"When she cries when I leave her, does it mean that she is really getting spoiled, or does she feel that I don't love her anymore, or doesn't she really like her caregiver?"*

Caregiver: *"Does it mean that she is just spoiled or is it that she doesn't like me since she cries in the mornings when her parents drop her off?"*

Discussion: We all like and are more comfortable with smiling out-going babies. Unless we have a firm grip on what is 'normal' during a certain phase of a baby's life, we might, indeed, panic and jump to all sorts of mistaken conclusions about 'the screaming baby' who wants to be held all the time.

During the first 4 or 5 months babies are not able to distinguish themselves as separate or autonomous from their caregivers. They are normally eager for attention from anyone and respond with smiles and happy gurgles. Then, at about 5 or 6 months of age, they suddenly begin to realize that they are not one with their parent and/or other significant caregiver. They fear that the caregiver can go away and leave them. This fear, known as "separation anxiety" is normal and is usually demonstrated by clinging, screaming and not wanting to be separated from this important and trusted person. Another normal change, which adds to the difficulty of babies in day care, is the beginning of "stranger anxiety" at about 5 or 6 months. This normal fear of strangers often peaks at 18 or 20 months. It is important that parents and caregivers understand and take time to emotionally support the baby during this time. To do so they should:

a. Allow the baby plenty of time to get to know and trust a new caregiver since a good attachment is formed through the opportunity to be near the caregiver on an ongoing basis.

b. Allow the baby to consistently go through a leave-taking ritual, such as having a good bye hug and kiss at the door and possibly waving good bye from a window. When parents deceive the baby by "stealing away" while his attentions are elsewhere, she will react by being anxious and confused, never quite being reassured that they can be counted on - this sets the stage for problems in building healthy, trusting relationships later in life.

c. The new caregiver should not force herself on the baby but allow the baby to come to her while always making it clear to the baby that she is available. She needs to help the new baby who reacts initially by refusing to have anything to do with her by taking care of the baby's physical needs as gently and smoothly as possible, telling her in gentle tones about what she is doing with her, but also respecting the baby's fear of her, the 'unknown' and letting the baby retreat to a distance more comfortable for her. During this period the caregiver needs to provide support by looking at (checking on) the baby often, commenting on what she is doing, giving her reassuring smiles and in general, letting her know that "she is with her".

Once the baby has decided that the new caregiver is another "security base" she may begin extreme clinging and whining, demanding to be held and carried at all times. Although this is exhausting for the adult, both physically and emotionally, it is essential to give the baby that extra reassurance. This experience will

satisfy her need to know that the caregiver is not only another security base but also a dependable one. One that she can strike out from and one she can trust to be there when she needs to return.

As the baby feels more secure she will be able to play more readily by herself and will lessen her demands on the adult. It is important that the baby not be forced to "cry it out", as this may only increase or prolong the baby's anxiety and crying or may cause the baby to withdraw.

Concern No. 5 -

Parent: *"What are some of the things I should look for when searching for a good caregiver for my baby?"*

Caregiver: *"What are the most important things I can provide for the babies in my care and for their parent(s)?"*

Discussion: Ask yourself the following . . .
Does the caregiver:
Do you as a caregiver:

1. truly enjoy babies and find it a pleasure to rock, hold, cuddle, talk and play with them?

2. recognize that babies, also, need short periods of time alone?

3. accept each baby as a unique individual, able to use different caregiving styles to fit individual needs?

4. support baby's emotional needs by responding without delay and by always being accessible?

5. provide a safe, open environment for babies to explore and test themselves against?

6. notice what the baby is doing and freely cooperate with baby-initiated activities and explorations?

7. give babies every opportunity to learn to do things for themselves while being present to provide encouragement and support?

8. provide a variety of materials for the babies to learn about through their sense of touch, smell, taste, sight and hearing? Are items too large to swallow or choke on, nonpoisonous and otherwise safe?

9. give good physical care to babies?

10. feel relaxed and confident in own abilities to work with babies?

11. see self as a model whose own actions, attitudes and values will influence the babies' development?

12. recognize the importance of the parent-child relationship and support this by making possible an open sharing and by showing respect for the parents and for the child?

Concern No. 6 -

Parent: *"How will I know if my baby's needs are met in day care?"*

Caregiver: *"What can I do to reassure the parents that together we can provide a good start for their baby?"*

Discussion: First, a good system of communication between the parents and caregiver is a must. This begins with a thorough and open interview during which the parents state their feelings and philosophies regarding what they want for their child, and the caregiver shares her feelings and philosophies regarding how she sees her role as the baby's other primary caregiver. If there are any major differences, these must be negotiated and a clear agreement arrived at immediately. A system must be set up for further negotiations as differences arise. In situations where differences cannot be resolved, both parties should be able to terminate the relationship without any feelings of guilt, since it cannot be expected that every parent's or child's needs can be met by every caregiver. There must never be any hidden motives on either side; this could cause the baby to become a mere pawn in a power struggle between the most important people in her/his life.

Secondly, an ongoing system of sharing the baby's progress, physically, socially and mentally, might be accomplished through regular formal or informal observations that the parents and caregivers share at set conference times, or through the use of a daily log as mentioned in No. 3.

Thirdly, both parent and caregiver should feel assured that good care is taking place if the baby shows signs of being healthy, happy, curious and generally seems anxious to tackle the next step in her development.

Finally, it is important that the adults in the baby's life recognize when there is an illness or a normal phase of development, such as going through separation anxiety, that might temporarily cause a personality change in the baby so that these problems are dealt with appropriately and not carelessly blamed on inadequate parenting or inadequate caregiving.

FAMILY ISSUES: BIBLIOGRAPHY

BOOKS

Bigner, Jerry J., Ph.D., Parent-Child Relations: An Introduction to Parenting, MacMillan Publishing Co., Inc. NY 1979.
This book explores the process of interaction by which parents and children affect each other as individuals and as a family. It recognizes the concerns of contemporary parents as well as of those who are contemplating becoming parents in the future. This is an especially timely and useful text for anyone teaching, and/or counseling in the areas of family studies, parenting and child development.

Friedland, Ronnie and Kort, Carol; Editors, The Mothers' Book: Shared Experiences. Houghton Mifflin Company, Boston, 1981.
As the editors state in the introduction, "This book was conceived out of the recognition that the transition to motherhood changes a woman's life abruptly and totally, and that knowing how other mothers cope with their feelings during these changes could provide necessary support and guidance" the editors set out to and succeeded in, conveying what it feels like to be a mother today by gathering answers from a great many mothers across the nation on the following questions: How does it feel not to nurse when today's climate is so unabashedly pro-nursing? How does it feel to have negative reactions to your child when you first see him or her? How does it feel to have no sexual interest in your husband for months after the birth of your child? How does it feel to relate to your own mother once you have become a mother? How does it feel to institutionalize a retarded child? How does it feel to be an unmarried or lesbian mother? They have, also, openly and frankly dealt with topics such as postpartum changes, the going-to-work/staying home conflict, stepmothering, being a teen-age mother, feelings about surgical deliveries and more. A special feature of the book is the sensitive use of poetry and photographs to supplement and enhance the text.

Grad, Rae, R.N., Ph.D.; Bash, Deborah, C.N.M.; Gyer, Ruth, Ph.D., Acevedo, Zoila, R.N., Ph.D.; Trause, Mary Ann, Ph.D.; Reukauf, Diane, M.A. The Father Book: Pregnancy and Beyond. Aeropolis Books Ltd., Washington D.C. 1981.
The Father Book is an outgrowth of the prepared childbirth movement, oriented to the father's perspective. It guides fathers-to-be through the experiences of pregnancy, childbirth, the early months and beyond. A recurring theme throughout is that of relationships: father with mother, parents with child. It does not prescribe a single course of involvement, rather choices are presented with outlines of alternative ways to meet the father's own needs, those of his partner and of the newborn infant. Chapter II, Interaction and Exercise, will be especially helpful to fathers who are looking for ways to give their baby a head-start toward emotional security and physical competence, by giving hints on how to engage their baby in activities that they both will enjoy.

Hamilton, Marshall L. Father's Influence on Children, Nelson-Hall, Chicago 1977.
Dr. Hamilton in this book gives a clear definition to the important role of the father in today's family and social setting. His intent is to help fathers better understand themselves and their relationship and obligation to their children. It is also a guide for mothers, would-be parents, students and professionals who live, work and study the role dynamics of the family.

Klaus, Marshall H., M.D.; Leger, Treville and Truse, Mary Ann, Ph.D., Editors. Maternal Attachment and Mothering Disorders: A Round Table, Sponsored by Johnson & Johnson Baby Products Company, Sausalito, CA 1974.
This booklet summarizes the presentations made by clinicians and researchers from different disciplines who have studied the development of attachment in parents of normal infants, parents of premature or sick infants, parents of battered or failure-to-thrive infants as well as students of the attachment process in various animal species. The main areas of concentration are on "Disorders of Attachment," "The Process of Attachment," and "Problems in Attachment." This summary reflects the Round Table participants stress on the many factors that can influence this very important time period (immediately after birth) in the life of the family, and simple but practical aspects of care, which can be implemented to help prevent the development of mothering disorders.

Lynn, David B., The Father: His Role in Child Development. Brooks/Cole, Monterey, CA 1974.
The author, a developmental psychologist, discusses the father's role in the child's socialization, sex-typing and social adjustment, along with other critical problems related to the father-child relationship. The book, throughout, integrates a vast wealth of relevant empirical data and theoretical analysis, using a multidisciplinary approach. A useful book for any student of socialization - behavioral scientist, teacher, clinician, social worker or parent.

Stinnet, Nick; Chesser, Barbara and Detrain, John; Editors. Building Family Strengths: Blueprints for Action, University of Nebraska Press, Lincoln, Nebraska, 1979.
This is a book of readings authored by family life educators, practitioners and researchers who presented their work at a national symposium on Building Family Strengths. The book promotes the formation of a positive family life model to help families and professionals helping families, strengthen and support the American family systems. The book's major areas of concentration are: I. Perspectives on Family Strengths, II. Family Enrichment and Counseling, III. Strengthening Families Through More Effective Parenting, IV. Parenting Children with Special Needs, V. Emerging Family Styles, VI. Enhancing the Quality of Life in the Middle and Later Years, VII. Epilogue: Where Have We Been and Where are We Going.

Walters, James, Editor. The Family Coordinator, Special Issue: Fatherhood, Volume 25, No. 4, Published by the National Council on Family Relations, 1976. This volume contains 25 articles discussing fatherhood based on studies pertaining to a great many aspects of the father role, such as the father's role in infancy, in sex development, the father in the single parent role, the absentee father, on becoming fathers, etc. Select articles will be of value to instructors interested in research data that provide some tentative insights into the role of the father in America, a subject that is just beginning to be explored and given long overdue attention.

PAMPHLETS

The following pamphlets* may be ordered from: Health Education Associates, Inc., 520 School House Lane, Willow Grove, PA 19090, (215) 659-1149

Adjusting to Parenthood series:

YOUR NEW BABY
Easy-to-read and equally appropriate for traditional families and single mothers. Helps new parents to understand what a new baby is like, and makes positive suggestions for dealing with the baby's needs. "What should I do when my baby cries?" "How do I know I won't spoil the baby?" (Single copy 7¢, 100 copies for $7.00 plus postage).

MAKING LOVE
Tactful yet frank discussion of sexual readjustment postpartum. Insight from a young couple's experience with the emphasis on solutions. "What Pam and Jeff realized this time is true for other new parents -- there are more than two choices of having intercourse or lying on opposite sides of the bed. Holding, cuddling, giving back rubs, massage are physical ways of loving that are especially appropriate for right after childbirth."
(Single copy 12¢, 100 for $12.00 plus postage).

Breastfeeding series:

FATHERS ASK: QUESTIONS ABOUT BREASTFEEDING
Lists the advantages of breastfeeding and explains how the father can participate. Good for expectant or new parents. "What about nursing in mixed company?"
(Single copy 7¢, 100 for $7.00 plus postage).

TIME OUT FOR BREASTFEEDING MOTHERS: GOING OUT, GOING TO WORK, GOING TO SCHOOL
Gives practical help and encouragement for the modern woman who wants to combine breastfeeding along with other commitments in her life. Ideal for mothers who are afraid that nursing will "tie them down."
(Single copy 17¢, 100 for $17.00 plus postage).

*For price list and information on additional materials, call or write to above address.

AUDIO-VISUAL DISTRIBUTORS

Updated catalogs may be had by writing or calling most of these services.

Audio Visual Library Service
Continuing Education and Extension
University of Minnesota
Minneapolis, MN 55414
(612) 373-3810

DPW Film Library
Oak Terrace
County Road 67
Minnetonka, MN 55343
(612) 934-4100, Ext. 252

Minnesota Curriculum Service Center
3554 White Bear Avenue
White Bear Lake, MN 55110
(612) 770-3943. Outside Metro Area (612)
Call Toll Free 800-652-9024
For Minnesota residents only, on a first come first serve basis, No reservations.

Modern Talking Picture Service
9129 Lyndale Avenue S.
Minneapolis, MN 55420
(612) 884-5383

New York University Film Library
26 Washington Place
New York, NY 10003
(212) 598-2250

Project Childsafe
Minnesota Safety Council
170 Hamm Building
St. Paul, MN 55102

FAMILY ISSUES: AUDIO-VISUAL RESOURCES

The following filmstrips are available from the Minnesota Curriculum Services Center.

UNDERSTANDING PARENTHOOD

Prepared under the supervision of the Editors of Parents' Magazine in consultation with Mrs. Saide Hofstein, Director of Education and Training for the Mental Health Association of Nassau County.

The series focuses on the problems and challenges of parenthood--to help parents and prospective parents achieve greater success and satisfaction in their parental roles.

Approximate running time: 120 minutes for entire set. The following titles included:

THE ECONOMICS OF PARENTHOOD
Laying the Ground Work
Nine Months to Get Ready
Now there are Three
Baby Begins to Grow
It's Time for School

THE GROWING PARENT
New Responsibilities, New Strengths
Opportunities for Self-Understanding
Communication: The Key to Growth
Belonging to the Community
Love Takes on New Meaning

CHILDREN
The Family Experience
What About Fathers?
Children as Scapegoats
Encouraging Independence
Why Family?

FAMILY RELATIONSHIPS
Becoming a Family
Differences, Great and Small
Expectations Versus Realities
Individual Needs
Talking It Over

CHILDREN IN CRISIS

Prepared under the supervision of the Editors of Parents' Magazine in consultation with Thomas Daniels Yawkey, Assistant Professor of Early Childhood Education at the University of Wisconsin-Madison.

The set is designed to familiarize professional, paraprofessionals, and parents with the child's reactions to the hardships of life, and ways in which parents and care givers can recognize when a child is in stress, and help that child understand and learn to deal with his anxieties and fears.

Approximate running time: 135 minutes for entire set. Includes the following titles:

CHILD ABUSE & NEGLECT
A Crippling Disease
Discipline Versus Abuse
Who is the Abuser...Who, the Abused?
How Can We Tell?
Treatment and Prevention

DEATH
Death as a Reality of Life
Expressing Grief
Ages of Understanding
Explaining Death to Children
The Importance of Funerals

ILLNESS
Illness and the Family
When a Parent is Ill
A Child's Reaction to Illness
Going to the Hospital
Readjustment to Health

DIVORCE & SEPARATION
When Discord Upsets the Family
Through the Child's Eyes
Telling the Children
The Family Apart
Accepting the New Lifestyle

WORKING WITH CHILDREN A Commitment to Caring

Produced under the supervision of the Editors of Parents' Magazine in consultation with R. Virginiz Burke, Child Care Coordinator, National Institute of Health.

UNDERSTANDING THE RESPONSIBILITIES
OF CHILD CARE
Child Care and Child Development Today
What is Good Quality Child Care?
Qualities of Good Caregiver
The Caregiver's Tasks
Employment and Educational Opportunities

* *

The following 16mm films are available from the DPW Film Library.

TOUCHING

Dr. Ashley Montague narrates on the value of touch in communicating during therapeutic sessions. Describes need for touching in various stages of life. Compares sense of touch to other senses and points out the need for the sense of touch in order to survive. Color. 40 minutes

TEENAGE FATHER

Composite of young men who share with interviewers their innermost thoughts and feelings about the experience of being involved as an unmarried teenager in an unplanned pregnancy. Color. 30 minuts.

GROWING UP TOGETHER: FOUR TEEN MOTHERS AND THEIR BABIES

Follows the daily lives of four teenage mothers, who tell their own stories in their own words and by their interaction with parents, friends and others who make up their world. It does not editorialize or make judgments. It is simply a documentary, whose goal is to generate discussion and raise questions in the minds of both parents and young people. Color. 55 minutes.

BARB: BREAKING THE CYCLE OF CHILD ABUSE

Not surprisingly, abusive parents are often former victims of abuse or neglect themselves. Barb was such a parent--neglected herself, she had trouble coping with the responses and needs of her tiny daughter. The film shows that abusive parents can learn to be successful parents. (Motorola Teleprograms Inc., 1977) Color. 28½ minutes.

WAR OF THE EGGS

This heart-rending, incisive story dissects the anatomy of a modern American marriage. A young couple quarrel bitterly. As a result, their 2-year-old son begins to cry hysterically. This enrages the wife who shoves him down the stairs, badly injuring him. While the child undergoes emergency surgery, a staff psychiatrist tries to help. At first, they deny anything is wrong. Sally claims the child's injury was accidental. John retreats behind an unfeeling suit of armor. When the psychiatrist begins to probe, they blame each other. Sally berates John for being more interested in his job than in his wife and child. He denies this, claiming she is a poor mother and housekeeper. Under the gentle questioning of the psychiatrist, their defenses begin to crumble and they are brought face to face with their basic problem; self-hatred. John is afraid to feel for fear of what it will tell him about himself. Sally got her opinion of herself from a rigid father who taught her she was good only when she behaved herself. Painfully, husband and wife open to each other, accept responsibility for what they have done, and turn outside themselves for help. (Paulist Productions). Color. 30 minutes.

* *

The following filmstrip may be previewed for purchase from Toys 'n Things.*

CHOOSING CHILD CARE

A filmstrip which outlines options in child care and choice--seeking guidelines, to help parents feel better equipped making a decision about child care.

*See order form at end of Guidelines.

Infant-Toddler Growth and Development

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AN INTRODUCTION FOR THE INSTRUCTOR

When we began to write this section on normal infant toddler growth and development, we found we needed to make some assumptions about you, the instructor who will use this guide as an aid in teaching parents about their babies.

1. Your knowledge about infants and toddlers may have been gained as a parent, by having read every book and study written on the subject and having attended a variety of both formal and informal classes and workshops. Or you may be someone who has had very little exposure to infants and toddlers and little or no formal or informal training.

2. You all care about, but have different perceptions of, parents' needs in relation to their parenthood.

3. You are probably involved professionally in a related but different area.

4. Your time and background may make it possible for some of you to say, "I would rather write my own curriculum but this will be helpful as a comparison." At the other end of the spectrum, you may be feeling, "I have neither the time nor the resources to teach such a class, but I do feel there is a need and I will tackle it with some help."

Our dilemma, then, was for which of you do we write? We chose a rather detailed approach to enable those of you with little experience, but lots of enthusiasm, to have a solid start; providing guidance until you eventually are able to design your own curriculum. At the same time, we feel these guidelines will serve as a useful tool for those of you who are ready to write your own curriculum and are primarily interested in resources, or some additional ideas.

For the sake of clarity, the text of this section refers to the generic *he* throughout. It is regrettable that our society has not yet found a way to acknowledge the equal number of *shes* in our language without awkwardness and confusion.

HOW THIS UNIT IS ORGANIZED--HOW IT MIGHT BE UTILIZED

This section is designed to give the instructor the option of teaching a series of classes topically or chronologically, as each topic is dealt with n chronological phases. This will allow you to plan classes or workshops either by topic or by age grouping, whichever best meets the needs of the potential participants.

Some examples:

1. Five two-hour classes: On "Infant Toddler Growth and Development" presented by chronological age (developmental phases) covering all the topics as they relate to each phase.

2. One two-hour workshop: On "The Emotional Development of Infants--Birth through 14 Months" for the working parent who wishes to gain a better understanding of (1) the optimal time for career re-entry after birth; (2) what to look for in a substitute caregiver in order for both the parent and the baby to feel safe and secure. In this type of workshop the instructor could emphasize the normal phases of social/emotional development of the infant through the first year, and use the Sharing in the Caring handout, see p. 79.

3. A series of classes: Designed for a special group such as adolescent parents. For this group the instructor may feel that teaching child development strictly through a "hands-on" process will be the most beneficial, and therefore may choose to use the supplement, Things to Do for Baby and You as a core unit. The classes may or may not be attended by the infants. In any case, it will concentrate on helping the parents view their infants as exciting individuals to observe and become responsible for.

4. A developmentally linked sequence of classes: On "Keeping Up with Your Baby" for a group of parents beginning right after the birth of their babies through their babies' second birthday. The group might meet for several hours once or twice a month to share observations and prepare themselves for the next phase.

Some other class or workshop possibilities are:

--Interpreting Your Baby's Communications From Birth to Age Two.

--Guiding the Infant's and Toddler's Behavior by Working With the Grain.

--Giving Your Baby a Healthy Boost Through Good Nutrition.

--How To Let the Baby Be Your Most Important Teacher by Tuning Into His Cues.

--Creating a Safe, Yet Stimulating, Environment For Your Baby.

--From a Yawnful Stretch to a Full Run-A-Head In Two Short Years: The Baby's Physical Development From Birth to Age Two.

Using the Suggested Resources

Teaching Suggestions and Resources. The column Teaching Suggestions and Resources, gives suggestions for enhancing the content area through exercises, demonstrations or by providing supplementary information through instructor resources or participant handouts.

Films and Filmstrips. Specific films and filmstrips have not been listed in the Teaching Suggestions and Resources column due to the flexible nature of the curriculum, the topical diversity of film and filmstrip content and to the uncertain availability of any one film or filmstrip to the instructor. The instructor is advised to first carefully read through the Audio-Visual Resources beginning on p. 200. When the class topic(s) have been determined, choose the A.V. aids that seem most appropriate and order them for preview. After previewing, reserve those that best fit the class needs, the class schedule, and the program budget. Frequently films and filmstrips are introduced in the areas of child development, child health and child nutrition. The instructor can keep up with what is new and useful by requesting updated A.V. listings from the Audio Visual Resources listed on p.200 as well as those listed in the Health Concerns section, p.221, and by checking on what is available through local agencies and institutions. (See Finding Resources to Enrich the Curriculum p. 29).

Health Related Resources. The supplemental resource materials for the "Health Concerns" topic area (i.e., illness, safety, nutrition) of the curriculumare located in Health Concerns Resources, beginning p. 221. These are materials developed, and/or recommended by the Minnesota Department of Health. The instructor should read through these materials and be prepared to use them in whichever way he/she determines to be most appropriate when discussing health concerns.

Pamphlets. The instructor who prefers to use pamphlets as an instruction tool will find "Potpourri of Child Care and Development Pamphlets" useful as a resource. (See last page of this guide for description and ordering information). Pamphlets on a variety of topics can usually be found at local agencies and institutions. See Finding Resources To Enrich the Curriculum p. 29.

IDEAS FOR THE FIRST CLASS

Depending on the focus and backgrounds of the participants (socio-economic, educational level, etc.) you may or may not choose to include one or more of the following activities in the introductory class on infant toddler development.

- As an ice breaker for any infant-toddler-related class or workshop, pass around cards with words/phrases that relate to babies, such as crying, wet diapers, gurgling, etc. Ask participants to introduce themselves and give the first reaction they had to the word/phrase on their card. This can be used as a springboard for an introductory discussion.

- Discuss the characteristics of a well-developed child at three years. Make a chart based on the list in The First Three Years of Life by B. White, Chapter 7, page 168, or the paraphrased form of this list in the handout "Disciplining the Infant and Toddler." (See p. 192)

- Discuss factors to consider when talking about growth and development. List suggestions made by participants on the board (heredity, environment, instinctive behaviors, nutrition, general health and safety.)

- In order to emphasize the importance of focusing on the parent-child relationship as a means of laying a sound foundation for all of the baby's other learning tasks, introduce any highly "activity"-oriented class or workshop with the following exercise. Pass around the Baby's Most Important Resource Is . . . card (see Instructor Resource p. 189). Ask them to fill in the ending to that sentence, then open the card for the answer. (When group is seated in rows, it works best to pass the card from the rear of the group.)

- Discuss the issue of tests that their babies may already have had and will be given by their pediatrician, at well baby clinics, etc. Stress the fact that these are merely observation tools used to help the health professional and the parent be alert to any physical and/or developmental problems so that they can begin a course of action to optimally help the baby as soon as possible (see "Infant Assessment Tools" p.190).

- Display books on infants and toddlers (see Bib., p. 208) that pertain to the age group and/or topic area that this class will be concentrating on. Spend some time discussing in depth a few that you feel are really relevant, but be honest about your biases. It helps, even if you have your own copies to share, to bring some from the public library. This will help make participants aware of the fact that there is a place where for free, they can delve into areas of personal interest, to enrich their class experience. (This idea is equally relevant, in relation to turning the participants "on to" reading to/with their infants and toddlers.)

- Decide how you will incorporate the supplement Things to Do for Baby and You and introduce it to the class based on your decision. Or, introduce the content and how it can be used to the class, then as a group come to a consensus on how to use it. Some ways to use Things to Do for Baby and You are:

--As an observation tool. Hand out the section that complements the age group being discussed at each class. Participants will observe their infant, if at appropriate age, or write down what they remember from when their infant was that approximate age, filling in the blanks. Or they may use it as a practice observation tool by observing and recording the behavior and skills demonstrated by other appropriate age babies.

--As an activity guide. Demonstrate toys and activities suggested for age group being discussed. Hand out the appropriate section to encourage participants to make/practice toy activity at home; or set aside class time for doing projects that enhance that developmental phase.

--As model for a personalized baby's activity book. Give each participant the entire Things to Do for Baby and You Section at the first class. Suggest that they may wish to use it as a model for writing a book about their baby's growth and development.

Note: Be sure to allow for time when participants can share projects on a regular basis throughout the series of class periods.

PHYSICAL DEVELOPMENT

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Reflex Behavior		
Newborns react to changes in their environment through a variety of built-in automatic behavior patterns called reflexes, i.e., rooting, sucking, tonic neck, grasp, crossed extension, moro (startle), "walking", blink, and dolls eye.	Parents' awareness of these reflex behaviors make it possible for them to plan and interact with their baby more appropriately. For example, place a visual stimulant to the side of the crib instead of above while baby is still in the tonic neck reflex position etc.	Display pictures of babies in the various reflex positions.
Reflex responses are used by pediatricians as a means of assessing the neurological health of babies.		Briefly discuss commonly administered infant behavior and physical assessment tools, e.g., Apgar test, Neonatal Behavioral Assessment Scale, Bayley Scales of Infant Development. See Infant Assessment Tools, p. 190.
Gross Motor Development		If some parents indicate/express further concern or fear regarding perceptions related to their own infants' test results, suggest that parent discuss concerns with their pediatrician, or check with local health services to find a pediatrician, pediatric nurse etc. who might serve as guest speaker on this topic. See Finding Resources to Enrich the Curriculum, p. 29.
Muscle control begins at the head and neck area and gradually moves downward, from babies having little or no head control at birth to being able to balance head when held still at six weeks old to having complete head control by three months. Muscle control also develops from the center of the body outward.	Provide baby a safe place to practice head rearing and moving body freely, such as on blanket on the floor.	
Flail arms and clutch with their fingers when they feel like support of the head is suddenly removed. This is called the "moro reflex."	Support baby's head at all times.	Note: In gross motor development, as in other areas of development, babies may vary greatly - in order to reinforce this fact, instructor may select the following passages from Infants and Mothers by Brazelton:
Gradually uncurls from fetal position at birth to lying flat	Baby may enjoy massage and doing relaxing exercises as suggested in	

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
on his back, randomly moving arms and kicking legs by three months. - When in quiet alert state will be in the tonic neck reflex position (or as often called 'the fencers pose').	"The Baby Exercise Book" First Phase: up to three months. Parents must be aware that occasionally a baby will be tactilely defensive and may have an adverse reaction to being massaged.	See Bibliography, p.216. - Average Baby - two months. p. 77, 3rd para. "When the children.... as if he was trying to crawl." - Quiet Baby - two months. p.p. 85 & 86, 2nd para. "Laurie's crying seemed to...., and her mother responded gratefully by holding her more and more." - Active Baby - two months p. 97, 2nd para. "They reviewed Daniel's excessive activity and....said he seemed to be a month ahead of himself."
At around three months most babies are no longer ruled by reflexes and may now be able to hold their heads up and twist their bodies from side to side. May shift positions. Can place arms over head in play when lying on their backs, can move arms and legs rhythmically. Can randomly bat at cradle gym. When they discover that it reacts, they tend to react with more vigorous batting.	Parent must always use safety restraint or place hand on baby when baby is on raised unguarded surface. Play with babies by moving their arms over their heads and down again, one at a time, both together. Gently and slowly pull babies up to a sitting position by their arms. Place colorful cradle gyms above the babies so that they can bat or kick at toys above them, or place a sock puppet on a foot for short periods.	If available, introduce and demonstrate some of the materials, e.g. tapering cushions, large beachball, cylindrical cushions, rag doll, etc., as described in The Baby Excercise Book, see Bib., p. 216. Demonstrate appropriate toys. See supplement, Things to Do for Baby and You.
Fine Motor Hands gradually move from being in close-fisted position at birth to being mostly open-fisted by three months old, when awake.		Demonstrate recommended toys and equipment for this age. See supplement, Things to Do for Baby and You.

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
At birth 'grasping reflex' causes baby to respond (grasp) to any object placed in the palm. This reflex gradually evolves to a voluntary ability to grasp at about three months of age or later. Babies then may clasp hands, finger a blanket at chest level, may bring fingers and/or objects to the mouth.	Let baby grasp adult's fingers while exercising arms. Provide safe items for baby to manipulate.	
Sensory Motor The baby learns about the characteristics of materials through the senses. The baby's ability to hear and feel in the intrauterine environment is expanded to being able to see, smell and taste at birth.		Demonstrate toys and activities as a visual reinforcer to discussion topic.
Hearing: The newborn is especially attracted to the sound of the human voice, in the higher pitch ranges when awake and the lower pitch ranges when drowsy. Learns to differentiate between different sounds by end of three months, e.g., the telephone ringing, footsteps approaching, or sounds of certain musical toys. Reacts to sharp noises by flinging out arms and stiffening whole body while still controlled by the "startling reflex."	At different times, whisper in baby's ear, shake a rattle near him, play a musical toy and sing to him. Provide quiet times also so that he won't learn to "tune out" sounds. Talk to him about what you are doing together. Provide cradle gyms that make sounds when they are moved and sound cans or rattles within baby's reach.	See supplement, Things to Do for Baby and You.
Seeing: Newborn locates visual stimulus by horizontal scanning - fixes on (prefers) dim to moderate levels of light. Can see most things	Position yourself so baby can gaze at your face. Hang a variety of colorful toys and/or household items on the side of the crib or next to where baby	

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
7 to 12 inches from the bridge of the nose. Is attracted to the human face, especially the eye-forehead area, from birth. By two to three months actually seeks out parent's eyes. Is also drawn to contrasting patterns and novel (to baby) sights. By the end of third month babies have near mature vision and can follow objects with their eyes that are up to ten feet away. By the end of the second month they may also be able to coordinate seeing and hearing.	is lying. The baby's best focal length is from breast to mother's face; it is, therefore, important that bottle-fed babies also be held so that they receive the same visual stimulation. While awake, place baby in infant seat on floor where he can watch you as you move about. Talk to him from different areas of the room.	
By the end of the third month, may turn head in a full 180° arc to keep a rattle in sight.	Move hand puppet or other interesting object up and down and around in a circle for babies to watch with their eyes.	Instructor may wish to use a large doll and a hand puppet to demonstrate to the class.
Smell: Babies react to strong odors and/or different odors from birth. Research suggests that babies a few days old know their mother's smell, and babies only a few weeks old seem to associate mother's smell with feeding.		For discussion on research documenting babies' abilities to use their various senses from early on read Infant Culture. See Bib., p. 210.
Touch: From birth babies begin to learn about the world's physical and emotional properties through their sense of touch. By one month old babies often react to differences in textures by being soothed when gently stroked with a soft fabric; aroused by vigorous	Basically, all babies need to be held and cuddled some of the time. In fact, the need to be touched, loved, cared for is as important to the baby's normal development, as food.	Briefly refer to supplement, Things to Do for Baby and You, discussion of "babystates" to help tune into opportune times for different kinds of touching. (a more detailed discussion on baby's states of attention takes place under Social/Emotional Development, p. 104.

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
rubbing with a terry cloth and squirming when tickled with a feather.		
By the end of the third month, some babies use their hands crudely as they begin to learn about the characteristics of materials by handling and flinging them, by bringing them to their faces for gumming, tasting and smelling.	Give materials that are safe to chew and explore such as a four-inch piece of telephone cord, texture ball, feely bug. Take baby on a feely walk through the house or yard. For example, carry baby to the window, place baby's hand on the drapery and talk about how it feels, then place hand on window, describe how it feels.	
Taste: Newborns have been noted to react to different tastes such as salt, sour, bitter, sweet, etc. much as adults do.	Since babies' taste buds have not been dulled by exposure to certain chemicals, etc., parents need to respect their baby's aversion to some things (juice, for instance, if the doctor has recommended it this early), as it may be simply too strong for him.	

SOCIAL/EMOTIONAL DEVELOPMENT

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Each Baby Is Unique Some may be very passive, some very active, others fall somewhere in between.	Parents need to be aware of each baby's uniqueness. The passive baby who does not readily get the adult's attention through cries and smiles still needs human contact and physical and sensory stimulation for normal growth and development.	After discussing general characteristics with participants, have each parent spend 5 minutes quietly reflecting on their child's way of interacting with the people around them between birth and three months of age. Then have them either verbally or on a piece of paper write down their reflections. Ask them to share (volunteer) their observations as they relate to the following points:
The baby may exhibit a reflex smile the first week of life. After that, and at different rates, babies may smile in response to different stimulations such as any smiling face, observing someone placing a human-looking mask over face, or at a mobile, etc. The baby may also show extreme pleasure by smiling, gurgling, waving arms and kicking feet simultaneously as a sign of greeting to parent, breast or bottle. The true social smile, however, does not emerge until after three or four months.	Give baby lots of opportunities to see and react to faces and various expressions. Talk to baby at every opportunity. Play games like "Where is _____'s nose?" Imitate the sounds the baby makes.	• My baby used to show his/her pleasure by _____. • She/He smiled for real when s/he was _____ old. • My baby seems to know the difference between _____ and _____. I can tell by the way s/he _____.
Most babies will, by the end of the first month let their parents know what their needs are by using different cries for when they are in pain, hungry, wet or simply lonely.	Babies must have their cries responded to as they are now beginning to establish a trust relationship (attachment) with their closest caregivers. Tending to their cries helps them understand that the world is a predictable and secure place in which to operate. It	• I can pretty much tell what my baby wants because s/he (cries in a certain way for certain things). or, I'm still not too sure what my baby wants, so I _____ _____.

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
	also assures them that they are worthwhile and valuable,....a critical factor in promoting the baby's sense of self esteem.	For a good discussion on the development of baby's smiles, read Knowing and Enjoying Your Baby by Alan Sroufe. See Bib., p. 213.
Baby States of Attention.		See supplement, Things to Do for Baby and You.
Newborns operate in definite "states of attention":	The mother-baby dance	
1. Regular or Deep Sleep		
2. Irregular or Light Sleep		
3. Drowsy		
4. Alert Inactive		
5. Awake Active		
6. Crying or Fussy		

COGNITIVE/LANGUAGE DEVELOPMENT

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Cognitive		
Some research indicates that babies 'learn' through conditioning by the use of positive and/or negative reinforcement from birth.	Through consistant interactions with his parent(s) the baby soon learns what to expect and how to produce certain interactions.	Chapter 5 of Infant Culture, see Bib., p. 210 discusses a variety of studies on learning through conditioning.
Language		
Crying is the baby's first step in communicating. From birth babies cry in different ways and learn that these can be used to get different responses when the caregiving adult is tuned in to his needs.	Try to answer the baby's cries so that he will soon learn that he is able to communicate his needs.	When discussing this section, be prepared to deal with the issue of the colicky, fussy baby or the baby who uses crying as a means of releasing built up tensions. See Building On Behaviors and Nurturing Relationships, p. 107.
Baby begins to make accidental throaty noises, grunts and sighs, at first and does so regularly by the end of the third month. Often coos, smiles and blows bubbles when someone comes near. Begins to perceive voice gestures and body language of the adult.	Reinforce the baby's sounds by repeating them after him. Be sure to use 'honest' voice gestures, since baby understands a lot more by how an adult says something at this time than what he says.	For a more in depth discussion on crying as a tension release, read Infants and Mothers by T.B. Brazelton. See Bib., p. 208. In order to help parents understand importance of this advice, share with the class research data on early language development discussed in Infant Culture, see Bib., p. 210.
Baby may, also, entertain self with comfort sounds or "talk" to mobile or other toy within his visual range.	Give baby time alone to practice these early language skills, as they are self reinforcing.	

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Even though the baby does not understand words yet, he is beginning to learn the mechanics of language and the purpose of words. Researchers have determined that from birth the infant is learning the rhythm of language, movements and gestures.	Talk to/with the baby as a way of including him in the daily interactions of bathing, dressing, changing and feeding him.	

BUILDING ON BEHAVIORS AND NURTURING RELATIONSHIPS

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES

Note to Instructor: This is perhaps the topic area in which you, as the instructor will have the most direct impact in affecting parents' behavior to lessen the possibility of child abuse (a potential within each and everyone of us). It might, therefore, be useful for you to read or re-read A Model for Understanding Abuse and Neglect of Children, a summary of characteristics of abusive parents. See p. 57.

Behavioral Considerations of Babies and Adults

Babies are all different -- some are very active, some very passive, others somewhere in between -- some cry a lot, others smile a lot -- some sleep a lot, others are awake a lot.

Parents are all different -- each with different tolerance levels; some operate smoothly and gently, others vigorously and others intently.

Babies operate on a reflex/instinct level -- are coming more or less from ground zero, but are already processing the world through the use of their senses.

Parents operate on an instinct/reflex level tempered a good deal with life-experience conditioning.

Parents should in the early days and weeks observe the infant closely in order to:

1. learn what sort of an individual he is,
2. learn his cues and signals to them,
3. learn the baby's responses to the way they do things to/with him,
4. note how adjusting their techniques in different areas may enhance their relationship with the baby.

Parents must be mindful of the fact that the baby's actions (crying no matter what they do for him, rejecting stimulus, etc.) are not a reflection of how he feels about them; rather, simply his way of coping with the world at this time.

An excellent resource on learning to observe children is Tuning In To Your Child. See Bib., p. 214. Useful for instructor and/or participants.

When discussing differences in babies the instructor and students will find Infants and Mothers by T.B. Brazelton an excellent resource. See Bib., p. 208.

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Babies have extremely limited intellectual capacities. Parents have well developed intellectual capacities (reasoning abilities).		
Babies, initially, show their needs through crying or fussing. Parents want to understand and provide for their baby's needs.	Parents need to provide for the baby's total dependence on them at this time as it lays the foundation for his ability to become gradually more and more independent throughout the developing years. They will not spoil him by picking him up when he cries.	
Babies have behavioral "states".	Parents who recognize and understand the baby's "states" will be more successful at developing a rich and rewarding relationship with the baby.	Refer back to supplement, Things to Do for Baby and You, discussion of "babystates".
Some Specific Behavior Problems During the First Three Months of Life 1. Never quite sleeping, never quite awake	Parents need to think of themselves and their needs and take positive action to meet these needs when they recognize that: 1. It is easier to organize one's life when one can anticipate when the baby is going to be asleep or awake. To ensure that the baby gets this idea from the beginning "put him to bed when he needs to sleep" and "get him up when he is awake." The baby will learn to associate sleep with sleeping places and being awake, eating, playing, socializing, etc. in other places.	Discuss how behavior management begins from the moment of birth as the parent: 1. cooperates with the baby by taking appropriate advantage of baby's "states" 2. helps the baby develop a good self concept by showing respect for his needs 3. helps the baby develop a trust relationship with them, which will help him develop healthy relationships with others.

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
2. Light sleeper	2. Normal household noises can go on whether baby is to sleep or not. Do not, however, allow for sharp, loud noises which will stimulate the startle reflex, or keep TV or radio going at all times as that will only teach baby to learn to tune out all sounds.	
3. Thinks he is nocturnal	3. It helps to use the same sleeping place (crib & room) each night, to follow same pre-nighttime routine, e.g., dressing in night clothes, singing a quiet lullaby, etc., to keep the room dark, warm enough and reasonably quiet. It helps to keep night feedings sleepy and brief - rather than the social occasions they are during the day.	

<u>The Especially Fussy Baby</u>

Some babies are hypersensitive to the climate and stimuli around them, according to Dr. Brazelton. Parents are then often tempted to try in too many ways to quiet them; these efforts only having the effects of building up more tension in the baby which sets up a cycle of crying that may grow from two hour periods to eight and twelve hour periods of crying.

Parents need to observe their baby's crying patterns/habits and their reactions to their environment. Is their crying temporarily distracted by some visual stimuli? Do they quiet when they are rocked, when given a pacifier or made warmer or cooler? Do they seem to have ways of quieting themselves, e.g., sucking their fist, rocking their body, etc.?

Parents may actually record the time and circumstances surrounding their baby's periods of seemingly excessive

Ask parent/participants who are troubled by their baby's excessive crying to document the times and all events surrounding their baby's crying spells, other than when he is crying from hunger, being wet, in pain and lonely, for one week. Also share with them some resources you might have such as sections on crying (see index) as discussed by Dr. Brazelton in <u>Infants and Mothers</u>; by Penelope Leach in <u>Your Baby and Child from Birth to Age Five</u>
see Bib., p. 210.

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
	crying. (Many are often surprised to find that their baby isn't crying as much as they thought he was.)	Refer back to supplement, Things to Do for Baby and You, discussion of "babystates".

Note to the instructor: An excellent series of pamphlets which would be especially useful in "setting the stage" for ongoing discussions on babies' needs is Love is for Everyone. These are five illustrated leaflets: Babies and Touch, Babies and Talk, Babies and Time, Babies and Trust, Babies and Teaching. Low reading level. Provides a good supplement to classes for adolescent parents, etc. (Multiple copies unavailable from source. Permission to duplicate can be obtained from: Susan Rothman, Coordinator Family Day Care Programs, Pennsylvania Department of Public Welfare, Room 423, Health and Welfare Building, Harrisburg, PA 17120.)

HEALTH CONCERNS

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
<u>Physiological Signs That Are Normal During the First Two to Three Weeks of Life</u> (but should be checked by physician if they continue beyond that time) 1. Skin: - Bluish hands and/or feet - Blue patches "Mongolian blue spots" on children of Negro, Oriental or Mediterranean ancestry - Milia - Birthmarks - Peeling skin - Cradlecap 2. Hair: - No hair - lots of hair - Hair falling out - Body hair 3. Head: - Oddities of shape (cephalhematomas may not totally resolve until three months of age) - Fontanels "soft spot" (normally present to between ages 18 to 36 months)		Instructor may wish to prepare a check-off sheet for parents to help them identify any areas that require action after baby's first two weeks and to help relieve any undue anxieties.

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES

4. Eyes:
   - Swollen, puffy or red-streaked
   - Yellowish discharge and/or crusting on lids and lashes
   - Squinting
5. Ears:
   - Sticking out
6. Mouth:
   - "Tongue Tie"
   - White tongue (this is not to be confused with thrush)
   - Blisters on the upper lip (from sucking)
7. Breasts:
   - Swollen
8. Genitalia:
   - Edema of labia or scrotum
9. Abdomen:
   - Umbilical hernia
10. Sex organs:
    - Large genitals
    - Scrotum or vulva inflamed, red-looking
    - Tight foreskin
11. Eliminations and Secretions:
    - Meconium
    - Blood in the stools
    - Pinkish hue on the diaper
    - Frequent urine
    - Mild and transient vaginal bleeding
    - Vaginal discharge
    - Tears
    - Sweating
    - Spitting up

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Ongoing Safety Principles		
Reflex behavior may cause newborn to inch off, or flip off a high surface. A new skill, such as turning over, may suddenly be acquired without warning.	Never leave baby (even newborn) alone on changing table, bed, in infant seat, couch, etc. without proper use of safety harness or adult hands.	Have participants brainstorm an ongoing safety principles list. Write ideas on board, leaving space for an additional list of suggestions on how to solve any particular problem in conjunction with each point. The second column may be done simultaneously with the first list or as a follow-up exercise.
Many babies have died tragically in home fires where they were left unattended.	Never leave baby alone in the house, not even for three seconds!	
Children left unattended in cars and carriages are vulnerable to unscrupulous characters and animals, run-a-way cars and carriages, and overheating which can become a life threatening situation.	Never leave baby unattended in a car, a carriage outside a store or out of your sight.	For more detailed safety materials check with the U.S. Consumer Product Safety Commission, Metro Square, Suite 580, 7th and Robert, St. Paul, MN 55101, (612)725-7781
Plastic bags or film placed by babies have caused many to suffocate and die.	Never leave plastic bags or film near baby.	
Baby powder is dangerous if inhaled and may be harmful to the eyes.	Never shower baby powder on or near the baby's face.	
Excess toys, blankets, etc. may cause baby to suffocate.	Never clutter baby's crib or carriage with excess blankets, pillows or other materials that might cause suffocation or strangulation.	
Babies' bodies can slip through widely spaced slats but the head will not, which can cause strangulation.	Never let baby sleep in a crib where the slats are more than 2-3/8" apart or where the mattress does not fit snuggly against the sides of the crib. Securely fastening bumper pads all around will alleviate problem until	

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
	baby grows too big to fit between slats. Stuffing blankets or towels in excess space between a too-small mattress and crib side will keep baby from becoming lodged in the excess space.	
Poorly constructed pacifiers may cause infant to choke. Be sure that they are constructed of one piece, and have a round shield too large to go beyond the baby's lips.	Never give baby pacifiers that are not made of one piece, and are small and pliable enough to become lodged in the throat.	
One of the primary ways babies learn about the characteristics of materials in their environment is by mouthing/tasting them. Such materials should, also, be free of sharp edges, splinters, etc. and be easy to keep clean.	Never give baby objects, toys or hard foods to mouth or gum which are less than 1½" in diameter or which may come apart while baby is chewing on them.	Emphasize that it is normal, even essential, for babies to put everything in their mouth as part of the learning process. Have parents make a list of the things they can think of in their home environment that they will need to change or be conscious of in order to safeguard baby in the up-coming months, e.g., never placing baby near appliance cords of any kind, etc.
Babies during this age period cannot chew or safely swallow medicine in the form of pills, capsules or tablets.	Never give baby medication in pill or tablet form. When medication comes in a solid form, dissolve in an appropriate liquid first. Check with pediatrician before administrating any medication.	

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Child should ride in a crash-tested, age/weight appropriate car restraint, beginning with his first car ride. Car accidents are the no. 1 killer of children under age five.	Parents often feel that their baby is safest/most loved when held securely in their arms. However this practice makes a flying missile of a child in the event of a collision.	Show and discuss "The Perfect Gift" or other appropriate film raising parents' awareness of the importance of using proper care restraints. See p. 207.

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES

Common Health Problems
(In order of prevalence seen beginning with infancy)

Diaper Rash: Some babies are more prone to diaper rash due to extra sensitive skin, especially fair-skinned infants. Inflammation is caused when an irritant is in direct contact with the skin.

Signs and Symptoms: Redness in the diaper area, slight swelling of the reddened areas and what appears as a "thickening" of the skin, with shiny areas and deepened skin lines.

CALL THE DOCTOR WHEN: the rash becomes weepy, runny or has pus in it. Another type of diaper rash is caused by yeast. This appears as a red rash with a silverish center. Little pimple-like spots appear around the edge of the rash. Refer this rash to your physician also.

To prevent a diaper rash -
- change baby's diaper when wet or after baby has a bowel movement.
- wash the skin in the diaper area with water and dry thoroughly. Use a mild soap to wash off stool.
- apply a barrier to protect the skin from breaking down such as lotion or vaseline.

If a diaper rash occurs -
- wash area with clear water and leave diaper off for 30 minutes three or four times a day.
- use an ointment to promote healing, such as Desitin, A&D or Zinc Oxide.

Spitting Up Milk: Spitting up after a feeding may be a small amount of formula/breast milk or a larger amount. It's nothing to worry about. All babies do.

It may help lessen baby's spitting up tendencies to:

1. feed him in a more elevated position
2. handle him gently after feedings
3. avoid baby crying a lot before feeding or during feeding
4. check to see that bottle is tilted sufficiently to have nipple filled with milk during feedings

Note for Instructor: Projectile Vomiting - Sometimes a baby's vomiting after feedings progressively becomes worse so that by the second to sixth week of life it has become projectile. This is the main symptom of a condition known as pyloric stenosis. This problem is most commonly found in boys and familial tendencies exist. The vomitus is not bile stained. Other symptoms include weight loss, constipation and excessive hunger. The baby sucks

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
	5. make sure the hole in the nipple is sufficiently large enough to allow several drips of milk per second when bottle is held upside down, 6. burp baby before, during and after a feeding.	eagerly after a feeding. For a more in depth discussion instructor may check "Pyloric Stenosis" McGraw-Hill Handbook of Clinical Nursing, N.Y., 1979, p. 372.
Bowel Habits: Babies' bowel habits vary. One baby may stool after meal and another may have a stool every two, three or four days. Breast fed babies' stools tend to be like yellow watery cottage cheese. Formula fed babies' stool looks like yellow-brown toothpaste. If the stools are hard and pebbly and seem to make the baby uncomfortable, he is constipated.	When your baby is constipated 1. offer extra water to the baby's diet for one week. 2. If this isn't effective, begin adding one teaspoon dark Karo syrup to each eight ounces of formula. 3. If still not effective, try one teaspoon, gradually increasing to one ounce of prune juice once or twice a day. 4. Apply vaseline to the rectum to help to ease the movement.	
Cradlecap: A seborrheic dermatitis, a common condition of unknown cause which may last for months. Signs and Symptoms: Weeping, oozing, and/or encrusted lesions which may extend over the head, down to the margins of the eyelids and ears.	Frequent washing of the child's head with a mild shampoo, making sure to rinse carefully, will minimize the problem. Also, be sure to keep the affected areas dry, clean, cool and free from irritation by clothing or other articles.	Stress to parents that seborrheic dermatitis is rarely of any medical consequence, although not very pretty. They may need to be reassured that this condition is only skin deep and will soon pass. In extreme cases, doctor may prescribe medicated creams for pimples or selenium shampoo for cradle cap. Care should be taken to keep medications or shampoo out of baby's eyes.

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Baby Acne: Also a seborrheic dermatitis which commonly comes and goes during the first three or four months, often reaching a peak around three or four weeks after birth. Area most often affected is the face, but may also develop on the scalp and the skin in the genital area. Signs and Symptoms: Red and swollen areas with pimples.	Wash pimply area with mild soap to remove oils and dry out area in order to avoid secondary infections. (Applying oils, tends to make pimples worse.)	
Prickly Heat: Often caused by overdressing or extremely hot humid weather. Most common on the back of neck, the ears, and the chest, beginning as a small patch and spreading.	Keep baby cool. Dress him in loose, light-weight clothes, which allow air to circulate. Use Calamine lotion on affected areas. Cool baths with baking soda added to water is soothing to the baby.	Note to instructor: Talcum and cornstarch have not been recommended, as recent studies are indicating that they may not be altogether safe or effective. The instructor may suggest that the parents check with their pediatrician regarding their use.
Eczema (atopic dermatitis): Inflammation of the skin usually appearing around three months of age in young children. May disappear by itself when the child is about three - five years old. It may develop into a chronic condition that clears up and becomes worse sporadically or it may occur as an acute condition that clears up permanently. Signs and Symptoms: Redness, crusting and dry oval patches of skin usually found on the inside of elbow, behind the knees or on cheeks, scalp, forearms and wrist areas. The rash is usually accompanied by intense itching.	Parent should attempt to moisturize area by giving child short baths, with minimal use of soap, patting the skin dry and applying skin moisturizers. Dress child in comfortable non-irritating clothing (especially avoid wool). And avoid strong soaps and shampoos. Since foods such as cow's milk, wheat, eggs, oranges, etc. may be affecting child's eczema it may be worthwhile to remove all such food from diet and reintroduce them one at a time over a period of weeks.	

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Common Cold: A viral infection of the upper respiratory system. Colds in infants (under six months old) are usually recognized first by a change in behavior and personality. Signs & Symptoms: Baby becomes irritable, restless and often runs a moderate to high fever. Has difficulty nursing due to nasal congestion. May also suffer from general achiness, vomiting and mild diarrhea.	Parent who is breastfeeding should offer breast often, but child who is on formula or regular milk should be offered other fluids, such as filtered apple juice, instead of or as part of fluid intake. Some doctors feel that milk products are mucus producing and do not have the immunizing properties of breast milk. Run a vaporizer, especially if child has a mild cough. Keep child warm, but not overdressed, especially in the case of a high fever. If a child has difficulty clearing thick or profuse mucus from his nose, the parent may use a soft rubber bulb syringe to gently suck the mucus out. Colds are often the child's first serious illness and parents should not hesitate to call their doctor for advice if they are concerned about specific symptoms or the child's temperature is 101°F or over, rectally.	Hand out or discuss "General Signs and Symptoms of Illness" Health Concerns Resources, p. 223. Some parents may not feel confident in their ability to correctly take their baby's temperature, read and interpret thermometer. To aid them in this process the instructor may wish to share the "Fever Control of Children" and "How to Use and Read a Thermometer" Health Concerns Resources, pp. 226 and 227.
Blocked Tear Ducts: Caused when the duct or canal between the nose and tear gland in the corner of the eyes does not open completely. Signs and Symptoms: Constant tearing from inner corner of the eye. Mild discharge and crusting around the eye.	Parents should soften crusts which form overnight by applying a warm wash cloth to the eyes for 2-3 minutes to gently loosen and remove them. Your physician will advise you on other treatments needed.	Advise parent to wipe from inner to outer corner of eye, and never over the nose from eye to eye. Demonstrate on doll.

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Eye Infection (conjunctivitis): Inflammation which surrounds the eye and linings inside of the eyelid. It can be caused by an allergy or by many different infections, viral and bacterial, as well as smoke, smog, chemicals or dust particles in the air.	To make the child more comfortable, gently apply a warm washcloth to the eyelids for a few minutes three times a day. Protect child from additional irritants such as smoke, airborne dirt and smog. Keep child's washcloth and towels from others to avoid spread of infection. If this doesn't help clear the infection in 24-48 hours or if the infection appears to be severe the baby must be seen by a physician. This is necessary to prevent the spread of the inflammation to the other eye or other people.	
Colic: A severe abdominal pain that recurs daily in some babies between the ages of two weeks and three months (occasionally lasting until the baby is six months old). Attacks usually occur in the evening, building up slowly over a couple of weeks, and may last several hours. Signs and Symptoms: The baby begins to scream as soon as he has finished feeding or goes to sleep but wakes up screaming within the hour. This is a frantic and quite different cry from those he uses the rest of the time. Baby draws legs up to the stomach and tightly clenches his fists. All attempts to quiet baby help for only a few	Once the parents have ascertained that their baby has colic (and it is important that no other physical or emotional trauma is causing the crying) the most important things they can do are for themselves. Some authorities believe a parent should attempt to ignore the baby's crying. But others feel strongly that the baby needs a parent's time and attention while the attacks last and that the parents should, therefore, structure the time so as to be free for coping during this period with the least possible amount of stress. At any rate, it is important that parents:	In order to help parents in the group who might be (or have) suffered through life with a colicky baby, provide them with additional resources to read which confirm the points that have been made in class, e.g., Your Baby and Child by Leach and Child Care by Greenberg. See Bib., pp. 210 and 214.

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
minutes. Some doctors feel that medications given one-half hour before the feeding which preceeds the colic is worth trying as it has been known to work for some babies.	1. Accept the fact that the cause is unknown, no one is to blame, and that in time it will go away as quickly as it came. 2. Find someone else to watch the baby once or twice a week; then go for a walk, shop, see a movie, etc. 3. Try to relax -- parental tenseness will affect the baby.	For further information the instructor may check: Sataloff, Robert "Otitis Media: A Common Childhood Infection" AJN, Aug. '81, p. 1483.
Ear Infection (acute otitis media): An infection of the middle ear caused by either a virus or bacteria. Most often the result of a common cold in the very young child. Pressure from congestion and swelling of tissues on the eardrum and on sensitive nerve endings around the middle ear can be extremely painful. Signs and Symptoms: In the infant, nonspecific irritability with or without fever may be the only symptom. Pulling or swatting at his ear is a common tip-off.	Parents should always seek their doctor's advice when baby exhibits any of the symptoms mentioned and should be especially observant of them during or after the baby has had a cold. It is, also, important to feed the baby in a raised position as those who are fed while lying down have a greater tendency towards ear infections.	Present this as anticipatory guidance: List on board type of scenario which may incur when ear infections aren't correctly diagnosed: 1. Child seems spoiled - crying for no reason, ear infection not detected and not treated. 2. Repeated ear infections cause temporary or permanent hearing loss. 3. Non-hearing child seems not to mind - is labeled bad. 4. Child becomes confused, frustrated, doesn't speak. 5. Child's disturbing behavior causes negative feedback from those around him. 6. Child in effort to be recognized acts out inappropriately or may retreat into a shell.

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Vomiting and Diarrhea: Most gastroenteritis or flu is typified by vomiting with diarrhea. The illness will usually be shortlived but may develop into a more severe form causing dehydration. A child having more than five loose stools a day is considered to have diarrhea. The stools are usually green and frothy appearing with a strong offensive odor.	Whenever these symptoms occur, a physician should be consulted. Diet is an important part of treating gastroenteritis. 1. Initially encourage the child. to take frequent sips (1-2 oz.) of flat 7-Up, ginger ale or Coke, Jell-O water, apple juice or Kool Aid for 24 hours. Give no milk or solid food. (Note: breastfeeding mothers should continue to breastfeed their babies.) 2. Second 24 hours, add Jell-O, popsicles, ripe mashed bananas, or apple sauce. 3. If vomiting or diarrhea is not controlled in 48 hours. Contact physician for advice.	Weigh child when illness starts. The doctor may want to know about any weight loss. Report to your physician 1. Signs of dehydration including decreased urine output (12-24 hours no wet diapers) 2. Sunken fontanel (soft spot) 3. Any bloody or fatty stools 4. Diarrhea lasting more than one week 5. Do not give any medicine for diarrhea unless doctor orders it. Note to instructor: There appears to be an ingredient, found only in Coca Cola, which has a stomach-settling quality.

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Childhood Diseases		
Measles, Mumps and Ruebella are common childhood diseases which the MDH* recommend children be vaccinated against in infancy. Diphtheria, Tetanus, Pertussis and Polio, although no longer common diseases due to effective immunization programs over the last years, can be real threats to the very young child who is not immunized against them.	By following the immunization schedule recommended by their physician or MDH, parents not only safeguard their infants against the immediate misery of being ill with a childhood disease, but more importantly, against secondary illnesses and complications which may have lifelong consequences.	Share with participants information provided in the following handouts available from MDH: Important Information-MMR Important Information-DTP Important Information-Polio and/or the sheets containing Questions and Answers on Ruebella, Measles, Mumps and Polio. Write or call MN Department of Health for order form for these handouts. It is also recommended that the instructor send for and read "Selected Recommendations of the Public Health Service Advisory Committee on Immunization Practices."
NUTRITIONAL CONCERNS		
Breast or Bottle?		
From birth on the baby needs certain types of nutrients which are supplied naturally in breast milk, but which can also be adequately reproduced in a formula.	The mother should choose the method of feeding the baby which is best for them (mother, father, baby) considering their life style, feelings and general needs; and not according to opinions of relatives, doctor (unless for a medically sound reason) or other well-meaning individuals.	Refer back to discussion on nurturing of family relationships and dealing with feelings as this can become a highly emotional issue. Also, if the group seems to need further discussion on the breast/bottle issue, present Bottle or Breast Feeding? Deciding Which Is Best For You. See handout, p. 242.

*Minnesota Department of Health.

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Some Basic Considerations About Infant Feeding		
1. Being held closely to the mother (or other caregiver) while being fed (bottle or breast) provides opportunity for the all important process of bonding or attachment building, which the baby needs for a healthy emotional development. Studies have shown that babies who have not had this emotional nurturance along with the appropriate food (breast milk or formula) have failed to thrive.	Parents must begin to see feeding times as being, perhaps, the most important times for building their relationship together. They need to understand that this is a time when the baby will be comforted physically and reassured of his self worth as he experiences the pleasures of touching, smelling, seeing, tasting, and hearing all that which is becoming more and more familiar to him. This is a one-on-one time with the baby - should not be seen as a chance to catch up on the latest magazines or TV soap opera.	Help parents set up a list of priorities. What are the things in their lives that tend to disrupt or make this important time with the baby less than they would like? How can they rearrange or eliminate tasks that tend to interfere with relaxed feeding times? How can they get enough rest so getting up for the 2:00 a.m. feeding is not unbearable? If there are participants interested in information on being a nursing and an on-the-go mother, share with them the resource Time Out for Breastfeeding Mothers - Going Out, Going to Work, Going to School. See Bib., p. 86.
2. Each baby is different and has different needs. Most pediatricians take this into consideration when they make feeding recommendations to the parent. As a rule of thumb - a baby who has five or six wet diapers a day is getting enough iron fortified formula or breast milk.		When participants indicate a need for an in-depth discussion on infant feeding practices see section on "Health Concerns Resources" beginning p. 221, e.g., Instructor References "Nutrition Services" p. 264 "Reference Materials" p. 266 "Nutrition Information, p.265 "Unit 12B" p. 253, "Unit C" p. 256 and "Transparency" p.248, and participant handouts, "Healthy Facts" p. 249 "Feeding of Infants and Feeding Milestones of Toddlers" p.244, and "Nutrition Bibliography, p.268 . Or use these resources as needs/interests are indicated by participants throughout the class sessions.
Introducing Solid Foods Babies, due to their immature digestive systems, may not utilize nutrients from solids properly. Too early an introduction of solids may lead to later food allergies.	Parents should follow their pediatrician's advice. (Pediatrician may recommend supplement of certain vitamins and iron.) Learn to stand firm against mothers, mothers-in-law, etc. who may have done things differently.	

PHYSICAL DEVELOPMENT

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Gross Motor		
Progresses from turning body from side to side, when on stomach to rolling from stomach to back and from back to stomach by the end of this period.	Provide baby with safe and clean surfaces to roll and manipulate whole body on. Place interesting objects around baby that he will wish to maneuver his body toward.	Discuss with the participants the following philosophies regarding encouraging the child's development at this point:
Begins to turn head in all directions and may hold it erect briefly. When lying on stomach on hard surface can raise head 90^{0} from that surface.		One school of thought feels that the human infant is so intellectually beyond his physical abilities, that they should be provided with support systems such as walkers, pillows, etc. to help them better explore their world and satisfy their intellectual curiosity, as represented by Burton White in The First Three Years of Life.
Next, will lift head and chest off surface. When on back, lift head and shoulders off surface. By the end of this period will turn head freely.		
May be able to sit, supported, for brief periods of time, up to 15 minutes at three months of age. By four or five months of age may sit supported for up to 30 minutes. By the end of this period will sit with only slight support or sit alone momentarily. (Some babies may sit totally unsupported, being able to balance well, and to lean forward and to the side. Others are still totally dependent on outside support. Yet, at the end	Place pillows or a Ring-Around-The Baby on floor for baby to practice sitting safely. If parent(s) feels, as some child development experts do, that the act of figuring out how to get into a sitting position by himself and how to maintain his balance is essential for baby's total development, then that parent will not provide supports via pillows, etc. Rather they will provide support via their own presence as they verbally	Another school of thought promotes the idea that the very acts of having to find solutions to sitting alone, crawling to reach an objects, etc. via the development of their own physical skills fosters intellectual development more quickly and naturally. Magda Gerber promotes this idea in her lectures and in the movie "The Way We See Them". See Audio Visual Resources, p. 206.

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
of this period. Both may be progressing normally.)	and emotionally encourage the baby to problem-solve and work out each step of the physical process.	
By the end of this period most babies have discovered a system of getting around to some degree, i.e., pulling along with arms, pulling legs up and pushing off or even scooting backwards.	To encourage practice of these skills place favorite toys just out of their reach while supporting their efforts to move with words of encouragement.	
Fine Motor		
At the beginning of this period hand swiping may still be random and inaccurate. Gradually move on to purposeful reaching and grasping, rotating wrists, turning and manipulating objects, lifting cup by handle, swapping objects from hand to hand. They are learning to let go of things. They like to shake, feel and kick things.	Toys to grasp and manipulate such as rattles or soft rubber toys. Things to let go of such as items that can safely be dropped from the high chair. And, of course, some one to pick them up for him (more social play).	Demonstrate recommended toys and equipment for this age. See supplement, Things to Do for Baby and You.
By the end of this period baby will learn to manipulate cup and spoon.	Provide an extra cup and spoon for baby to practice holding and manipulating as he prepares to learn to feed himself.	
Swallowing mechanism develops around three months.		
Sensory Motor		
Begins to coordinate eye head movement to follow a moving object or sound. Stares at source of a sound. Reacts to changes in volume and/or rhythm of music by quickening	Play "Hear-A-Boo." Hide to side of baby and call baby's name. When baby turns in right direction, show yourself.	See Health and Safety "Toys and Equipment Safety Check List," p.138. Emphasize that a most important avenue of learning for the baby, at this stage, is through the
	Let baby hear everyday sounds like	

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
or slowing body movements. Tends to scrutinize objects carefully with eyes. Wants to feel, hold, turn, shake, gum, mouth and taste objects.	running water, the vacuum running, cooking sounds, etc. Give baby ample opportunities to learn the characteristics of materials since this is one of his primary tasks at this period of his life. Provide items that have variety in the way they feel, look, sound, smell and taste, always making sure that they are safe. Provide visually stimulating things to explore--such as small interesting boxes, pieces of cloth, commercial bath toys.	sense of touch and taste, therefore, he should be allowed to explore items that are safe for him to put to his mouth.

SOCIAL/EMOTIONAL DEVELOPMENT

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Babies respond socially to attention by moving arms, legs and body in general, while smiling. When people around them show their enthusiasm by repeating sounds or movements that they make, they continue to do them even more vigorously. They laugh at unexpected sights.	Repeat their actions and sounds. Hold them in front of a full length mirror so they can respond to their own image. Make up rhymes about their eyes, nose and mouth.	
Babies will also, purposefully make noise to initiate social contact. They recognize parents and may show a strong preference for certain objects.	Socialize with the baby during his happy and content periods.	
When an especially enjoyable social interchange is cut off, the baby may start to cry.	When possible, continue social interaction until baby cuts it off, or try to distract baby with an object he is especially attracted to if parent needs to end interaction.	
By the end of this period, the baby begins to enjoy social games such as Peek-A-Boo, being tickled, etc.	Closely observe baby's reactions in social play to determine to what extent the baby can tolerate social games. Some babies enjoy having a parent babble at him in a rising crescendo, blowing raspberries on his neck, cheek or abdomen, tickle inside of hand with a washcloth or doing finger plays such as "There Was a Little Mouse" "I'm Gonna Getchu" or bouncing play such as "Ride a Cockhorse."	Help parents learn these social games, if they are not familiar with them, by either demonstrating with a baby, if one is available, or by using a large doll. See supplement, Things to Do for Baby and You.

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
May be showing fear of strangers and of being separated from mother or other attached person towards the end of this period.		See Building on Behaviors and Nurturing Relationships, p. 134.
Baby at this age may show rage become frustrated and lose control of himself.	Parent(s) must realize that this rage is not anger, rather an uncontrolled reaction to a particular frustration. It is a signal that the baby needs the parent(s) to help him control himself by being picked up, soothed or otherwise calmed.	
Baby likes to be included in family activites, such as meal times.	Be sure to allow baby to be part of family meal times either by scheduling his solid food eating at that time, or if it works better, feeding him first, then pull his highchair up to the table and let him explore some of the table foods via his newly developed ability to use his pincer grip.	Have participants share their observations regarding their babies' desire to participate in family activities.

COGNITIVE/LANGUAGE DEVELOPMENT

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Cognitive		
By the fourth month, baby has a memory span of approximately five to seven seconds. This gradually lengthens and is evident as he seems to remember his own actions of the immediate past, by the fifth and sixth months.	Parent and child interactions need to be somewhat consistent, so that the baby remembers happenings. For example, when baby grabs for parent's glasses, parent does not respond pleasurably, instead turns head away and consistently does so when baby grabs for glasses. Baby soon learns this is not how to initiate a social interaction with parent.	
At some time during this period, baby begins to smile and vocalize more to an actual face than to an image.		
Begins to discriminate faces, i.e., feels secure with mother's, but may resent a stranger's.	Give baby ample opportunity to get to know anyone new to him.	
Begins to see himself as separate from outer world and objects.		
Begins to adjust responses to people and their actions.	Notice how baby is attempting to cooperate.	
Initiates sounds and movements. May imitate a facial expression.	Play "Patty Cake" or make other movements or facial expressions for baby to imitate.	
Can discriminate self and mother in mirror.	Play with baby in front of mirror.	Suggest parents try the following activity to find out when their baby can tell that they are actually seeing themselves in the mirror. Place a black smudge

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Leans over to look for a fallen/ dropped object.		(something visible but not reelable) on their forehead. When the baby attempts to wipe it off himself after noticing it in the mirror, he has a true understanding of the mirror image. Parents should be aware that their baby may not make this association for several months yet.
By end of this period will reach for anything he sees.	Must be provided opportunities to use his physical abilities to satiate his driving curiosity	
Likes to look at things from different perspectives by turning objects upside down, etc.		
Scrutinizes objects at length.		
Calls parents (or primary caregiver) for help.	Always answer his calls for help by providing verbal or other emotional support/comfort, but let him try to solve his own problem before coming to the rescue.	The movie "On Their Own With Our Help" provides an excellent discussion on selective intervention. See Audiovisual Resources p. 206.
Understands own name.		
Language		
The baby's communication begins to change from crying for attention to babbling for attention during the fourth or fifth month.	Notice whether he seems to use his voice to get attention (like for his bottle), to show a dislike for something, or to show enthusiasm for something (mother or dad's voice,etc.)	Instructor may wish to recommend Teach Your Child to Talk by Pushaw. as a good resource for parents who are interested in learning more about their child's language development. See Bib. p. 220.
By fifth month responds to human sounds by turning head, looking for speaker. Turns head when own name is spoken.		
Begins to imitate a variety of tones at four months.		
By five or six months may utter vowels such as ee, y, ay, ah, ooh,	Notice the different variety of sounds the baby is making. Good time to begin	

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
and consonants like "ma-ba" or "pa-wa."	a tape recording of baby's language skills.	
Some babies by six months may even include consonants such as "f, v, th, s, sh, z, sz." They may also vary their volume, rate of utterance, and pitch.	Repeat the different sounds the baby makes when socializing with him.	
The baby's most important language skill is, however, still receptive in nature. He understands much of what the adult wants to convey by the sound of the voice; harsh, loud or pleasant, and gestures such as hand motions, facial expressions and body motions.	Notice whether he seems to understand when someone is talking in an angry or friendly way. Handle the baby gently. Use body language that matches the tone of voice. Describe activities being done together.	

TEACHING OUTLINE

THREE TO SIX MONTHS

BUILDING ON BEHAVIORS AND NURTURING RELATIONSHIPS

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Stranger Anxiety By three months of age, some babies react to family members with smiling enthusiasm but may view strangers with a solemn, reserved suspicious stare; others will react happily to anyone for another 3 or 4 months. Somewhere between five months to eight months of age, babies develop the ability to discriminate between trusted adults and strangers. A baby shows stranger anxiety by: 1. Turning away (refusing to make eye contact with someone unfamiliar to him). 2. Screaming, wailing or looking despondent when held by stranger. 3. Initially arching back and leaning away from stranger while being held or otherwise putting as much distance as possible between them. 4. Refusal to cooperate with stranger, e.g., not take bottle when hungry, disregarding favorite toy, etc.	Don't allow strangers to move in on the baby too quickly if he is showing signs of fear. Allow baby to make the first moves in establishing a relationship. Parents must be mindful of the fact that this is a real fear (and a sign of healthy emotional and intellectual development) in the baby; not a sign that he is spoiled or silly. (See Unit I Issues Concerning Family Growth and Development, The New Parent's Working Out-of-the Home Dilemma.) When strange adults are to take over caregiving responsibilities: 1. Baby should first be given ample time to learn about that person while protected by the security of the parent's presence, and a familiar environment. 2. Baby should be allowed to make the first moves in establishing rapport with adult.	It is very easy for parents to think of their babies as suddenly becoming 'bad' when they change from an outgoing 'loves everybody' type to one who behaves as if anyone who isn't his parent is a threat. They need to understand that at this stage of his development, the baby perceives others as a real threat. They should also be prepared for the fact that for some babies the stranger anxiety peaks at 18 months and that the more respect he and his anxieties (separation, too) are given through this trying period, the stronger and more capable he will be to handle new people and situations throughout life.

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Note: The intensities of these reactions will vary with individual babies' personalities, their past experiences (good or bad), their state of wellness, etc.	3. The baby should be responded to in ways that are familiar to him or with familiar items, e.g., a favorite toy or blanket to hold, be carried the way his parents usually carry him, spoken to in somewhat the same manner (it's especially frightening for a baby who is used to mostly gentle tones to adjust to harsh, loud tones).	Discuss how parents might handle the stranger anxiety problem when a grandparent or other relative comes to visit.
Separation Anxiety is another phenomena that might show up towards the end of this period. The baby reacts to being left by the person or persons (usually mother or other family members) to whom he has become attached, by: 1. Following attached person with eyes and staring at area where person was last seen. 2. Crying after and/or attempting to follow attached person. 3. Clinging to attached person with arms and legs, nuzzling into shoulder and neck of attached person when feeling threatened by stranger or in strange environment or circumstance. 4. When left in the care of stranger or non-attached person, will probably exhibit the same clinging behavior with her until	To help baby through separation anxiety 1. Play Peek-a-Boo in many different ways with baby. 2. Talk to baby from different room. 3. Give baby lots of time to gradually become familiar with new environment, new persons, and new circumstances while having the attached person there as a security base. 4. When leaving baby, whether for a short period, such as, five minutes or a whole day, be sure to follow a "good-bye" ritual - good-bye kiss, waving, saying when parent expects to return, and when possible let baby watch and wave after parent through the window. Parent should then leave, not linger, and always return at the time agreed upon. This helps the baby learn what to expect and that the parent can be trusted.	Refer to Things to Do for Baby and You, supplement.

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
parent returns, at which time he may only cling to parent again, or in some cases of lengthy separation, ignore parent and continue to cling to substitute caregiver, until he is ready to make the transfer.	5. Feel free to leave the baby on occasion or regularly if working, as studies indicate it will not hurt him as long as quality caregiving arrangements have been made for him, and he is given reason to trust the parent and caregiver. 6. Secure the best possible child care arrangement to avoid suffering excessive parental anxiety as it will only cause more anxiety in the baby if he detects those feelings.	Refer to the New Parents Working Out of the Home Dilemma, see p. 74.
First Steps of Detachment At the same time that babies at this age are developing a strong attachment to their primary caregivers, an ever increasing awareness and interest in their environment and the new ability to act on it is developing. This often causes mothers to feel rejected because the baby acts more interested in what goes on around him than in the breast, for instance.	Brazelton, in On Becoming A Family, stresses that parents need to understand that at about the time the baby is five months old they and their baby will undergo their first test of attachment. If the parents can allow the baby to turn away, try his wings in small ways, to detach himself in such a safe testing ground, they will prove the strength of their attachment to him and he will build on it to become his own person.	This is often an especially difficult phase for single parents. The instructor who is interested in an in-depth discussion on this and other problems single parents encounter at the various stages of their babies' development, should read On Becoming A Family, pp. 198-199. See Bib. p. 208.
Teasing Some babies seem to have developed the social capacity to tease by the end of this period.	Parents generally enjoy this ability and reinforce it by either initiating or playing along with baby-initiated teasing games. When these games are	

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
	played to the pleasure of both parent and child it is a healthy relationship-builder. However, it is important that the adult follow the baby's signals and stop when they create too much tension for him to handle. Parent should also model self-respect and stop teasing games that cause them displeasure.	
The Little Scientist Syndrome Towards the end of this period some babies will become fascinated by their newly developed abilit, to purposefully let go of objects; especially when they can be dropped from a sufficient height to cause a reaction like a loud noise, bouncing or rolling, etc.	It will help parents to view their baby's delight in throwing down everything (bottle, teething bisquits, rattle, spoons, measuring cups, etc.) placed on his high chair tray, as his way of learning through repetition, i.e, 1) Each time he opens his hand the object he is holding leaves his hand, 2) it always leaves in the same direction - down, and 3) different items present different reactions. It takes the baby countless repeated experiences, which provide the same result each time, before he can feel assured that this is how this particular part of his world works.	

HEALTH CONCERNS

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Toys & Equipment Safety Check List Three months to five months safety check:		Present "Accident Prevention and Child Safety" see Health Concerns Resources p.236.
Check clothing (yours and his) and stuffed toys for anything that might come off such as loose buttons, pompoms, small bells, removable appliques that might cause him to choke (anything less than 1½ inches in diameter).	Stuffed toys should be non-flammable non-toxic, preferably whole body cut out of one piece of material, features embroidered or silkscreened on lightweight and washable material.	Stress to parents that babies by four months of age may grasp anything their hands touch and will inspect it both with their eyes and bring it to their mouths to further inspect it through their sense of touch and taste.
Check all areas surrounding his crib, where he might be placed in an infant seat, baby swing, etc. for any type of cords, such as lamp, appliance or telephone.		Refer parents to The Complete Baby Book, A Total Guide to Buying Good Things for Babies; see p. 144 or provide handouts from Consumer Products Safety Commission to help them select the best possible commercial toys for their money.
Check to see that all straps designed to hold baby, e.g., bathinette/changing table, infant seat, etc. are well attached, or better yet, never leave him alone on a high surface.		
Four to five months safety check:		
While keeping the former in mind, check an entire room for open stairways, tippable furniture, low hanging table cloths, doors that can pinch fingers, etc. before putting baby down to play.	Parents should get down on the floor for a 'baby's eye-view'.	

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES

Take down or place mobiles out of baby's reach when he begins to pull himself up. (Mobiles are not toys to be played with.)

Common Health Problems

Introduction of solids to baby's diet will change stool whether bottle or breast fed. Stools may contain particles of undigested food and/or mucus.

Withhold food that appears to be undigestible or causing mucus, re-introduce at a later date (two-three weeks.)

Throat Infections

1. Virus: The most common cause of sore throats. It is typified by swollen glands in neck with fever. The throat appears red and may have pus on tonsils.
2. Group A Beta Strep: This is a less common cause for a sore throat. It also is associated with fever, swollen glands and red, pussy tonsils.

It is impossible for physician to determine from an examination alone which is causing the child's illness. A throat culture must be done to determine the prsence of strep. This culture requires 24-48 hours to be read. This is a very reliable test.

A sore throat caused by either a virus or strep will last for 3-7 days.

Antibiotics are only effective for treating a strep infection. (Will be of no help in treating a sore throat of viral origin.)

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
	Antibiotics must be given for a full ten days to be effective. Antibiotics are primarily given to prevent possibility of secondary complications. Must be begun within 11 days from time symptoms begin.	
Sty: (Hordeolum): A tiny abscess or boil at the base of an eyelash, often spreading from one lash to another. Sties last for several days. Signs & Symptoms: A small red swelling at the base of an eyelash, often develops a whitehead which bursts open and drains. The child will rub eye as a result of a burning sensation in the eye and feels something must be in the eye. Tearing also is present.	Place a moist warm washcloth over the affected eye three or four times a day for fifteen minutes or more. Doctor may prescribe an ointment or drops. To avoid spreading of infection, keep infected child's washcloths and towels separate from other family members.	

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Impetigo: A skin infection caused by streptococcus or staphylococcus bacteria commonly found in the environment. Thirty to forty percent of healthy people have staphylococci living in their nasal secretions and healthy newborns have staph around their umbilical cord and genital area. Infestions result when staph or strep overgrow often caused by lowered resistance and a break in the skin. Impetigo commonly appears on the face, arms, legs and diaper areas but will spread when not checked.	Provide infant with a clean environment. Frequently use soap and water to wash any areas where skin is broken due to a scratch or abrasion to help prevent the occurrence of impetigo. Call the doctor when: an infant develops a rash suggestive of impetigo. Treatment usually includes good cleansing and administration of an antibiotic.	For a more in-depth discussion on this topic, instructor will find it in: Cohen & Glass, "Skin Rashes in Infants & Children", A programmed instruction unit. AJN June 1978.
Signs & Symptoms are: Cluster of pimples with a red base. (With time the pimples open and drain, forming a yellowish crust.) The lesions tend to begin around the nose and face, but also occur elsewhere. Over time the lesion spreads outward with groups of lesions forming arcs and circles.		
Febrile Seizures: 8% of all children six months to three years may occasionally have seizures or convulsions associated with a fever. They do not cause brain damage. However, many serious illnesses start with a high fever, so contact your doctor if this occurs.	If you have never witnessed a seizure before, the first one will frighten you. While seizure is occurring: - place child on soft surface - position child on side - clear the airway	

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Signs & Symptoms: Seizures usually occur with a significant fever (above 102° F). One may occur before the child is known to have a fever. When a seizure occurs: 1. The child usually rolls eyes upward arms flexed, legs straight. 2. Respirations will be gasping, or breathing may cease for brief period of time. 3. Seizures rarely last more than a few minutes. (It will seem longer.)	When seizure is over - - remove saliva or vomiting from mouth with wash cloth over finger; - check your child's temperature and phone your physician; - child will seem to be in a deep sleep when seizure is over. He will gradually awaken in about an hour. Bring the child to a medical facility. Artificial respiration is not normally necessary. If child seems to stop breathing, begin mouth-to-mouth re-suscitation. If no pulse, begin exterior cardiac massage.	Every family should take advantage of First Aid Training -(CPR etc. courses offered in the community.)
Teething: Babies vary as to when their teeth come in. Most tend to get their first teeth at seven-eight months. By one year they may have two on the bottom and four on top. Signs & Symptoms: Your baby may begin to want to chew on whatever is handy. Sometimes the gums become red and swollen and the baby seems irritable.	A baby who wants to bite on hard objects can be given hard toast, teething rings, hard rubber toys, or cool spoons to chew on. Teething lotions that may be purchased are of little value. You may begin brushing your baby's teeth with a very soft bristled toothbrush or a Q-tip as soon as the baby's teeth are erupted and the gums are not swollen. A baby who has diarrhea, vomiting, abdominal pain or fever while he is teething, is ill in addition to teething.	

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES

NUTRITIONAL CONCERNS

Baby's Nutritional Needs

It is generally agreed that milk (breast or iron fortified formula) provides adequate nutrition for the first six months of life. Some babies, however, indicate a desire for solids earlier.

Most doctors today feel that solids should not be started until the baby is at least three or four months old and some parents and pediatricians may decide not to introduce solids until the baby is eight months old as long as the baby is doing well on the breast or iron fortified formula.

It is recommended that bottle fed babies stay on iron fortified formula for the first year rather than on unmodified cow's milk to get the appropriate nutrients. Low fat milks are to be particularly avoided since they may be low in essential fatty acids (which are necessary for normal development of the nervous system).

Parents may wish to introduce solids on their pediatrician's advice after they observe that the baby appears to still be hungry after his regular feeding, shows a great interest in food that the family eats, and when he seems to enjoy experiencing a variety of flavors and texture.

NOTE: Some babies may have difficulty managing meats, mashed potatoes or other sticky foods, parent can alter the texture by adding formula, breast-milk or water.

Recommended background reading for instructor; Recommendations for Feeding Normal Infants, and On the Feeding of Supplemental Foods to Infants, see Instructor Reference, p. 262.

Introducting Solids

Which solid food is first given will depend on family tradition, history of allergies, pediatrician's advice, etc. Whichever solid is chosen, it is best to first give it at one

Parent may choose to use commercially prepared or homemade baby food. In either case it is important to understand what the baby needs nutritionally. Parents should read labels carefully.

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES

feeding daily in addition to breast or iron fortified formula. After a week or two add a second solid to another milk feeding until after several weeks the baby is receiving a selection of solids at three of his feedings.

How Much to Feed the Baby

Allow baby to determine when he is full. (In all but a few cases, obesity in infants and children is the result of overeating.)

when using commercially prepared foods, and be aware of the nutritional needs of the baby and prepare homemade foods accordingly. In either case, avoid serving baby foods with too much sugar or too much salt. Keep an eye on baby for any possible reactions such as rashes, stuffy nose, sneezing, etc., within a week or so of each new food introduced.

Parents should be careful not to:

1. Regard feeding their baby as a means of expressing affection.
2. Make formula too sweet or too concentrated.
3. Introduce cereal into the baby's diet too early.
4. Offer too many sweet foods.
5. Put food into bottles, food syringes, etc.

Good resources to share with parents are: The Complete Baby Book (section on Feeding Equipment), by the Editors of Consumer Guide, A Fireside Book, published by Simon & Schuster, New York, New York, 1979; and "Feeding Your Baby With Love" from the Minnesota Dairy Food and Nutrition Council, see p. 266.

PHYSICAL DEVELOPMENT

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Gross Motor		
Head balance under control.		For excellent discussions and illustrations on baby's motor development through this phase, share with the class the "Using His or Her Body" sections (p. 236 and p. 328) from Your Baby and Child by Penelope Leach. See Bib. p. 210.
Raises up on hands and knees.		
Creeps, crawls or locomotes. He does this while in a sitting position by raising and lowering buttocks as he pulls forward with feet and legs, or he sits on side of flexed leg and propels with corresponding hand and opposite leg. Turns around while creeping and/or crawling.	Try not to interfere with baby's attempts at manipulating his body, but be there to cheer him on as he attempts each new skill in his own way. Be especially careful not to disrupt his concentration. He does not need any rewards beyond the sense of achievement he gets from accomplishing a skill and having it noticed by the most important person in his life.	
May learn to crawl upstairs, and with help, can learn to turn around and crawl downstairs. (See Health Concerns for safety precautions.)	Provide a crawl-over box, small crawling gym or place a gate three steps up the stairway for practice.	Demonstrate crawl-over box. To make: stuff a cardboard box, approximately 4" x 12" x 24", with newspapers. Tape securely shut. Cover with colorful contact paper.
Learns to stand, usually in the following order: - Assists by straightening legs when pulled into standing position. - Pulls self to standing position in crib, play pen or next to furniture.	Provide stable furniture, etc. for baby to pull self up against and 'cruise' along.	

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
- Stands briefly with one hand supported. - Practices standing unsupported next to a support. - Raises self into standing position by straightening legs and pushing off from palms, lifting trunk, or by flexing knees and pushing trunk up from squatting position.		
May learn to cruise or walk alone by end of this period.		
First cruises by side stepping along furniture or other supports.	Place interesting toys at opposide end of sofa, chair, etc., from where baby is standing.	
Cruises with one hand support, coordinating activities such as stopping, pivoting 90°, backing up, waving, carrying toys, etc.		
Walks with both hands held.	Often babies will resist walking supported by adult hands as it feels unstable and insecure to them. To avoid creating a sense of unbalance when walking baby, keep his arm at chest level and slightly forward.	
Takes one or two steps unsupported between two support objects while transferring from one source of support to another.		
Walks alone (many children prefer to continue crawling for some time after they have learned to walk).	Some babies are happier at first if they can clutch a pom-pom or some other easy-to-carry object as it seems to give them a sense or security.	As a visual aid, showing the various physical processes and toys and equipment that aid babies in this phase of development, the

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
	Babies who developed these gross motor skills early on in this period will enjoy practicing their skills by climbing onto stable furniture. Bean bag chairs, etc. Obstacle course with chairs, cushions, etc. Small climbing gym, a gate three steps up on stairway. Balls to kick and throw.	instructor may wish to make a collage from magazine pictures of babies. Stress that it is normal for some children to continue crawling after having mastered walking.
Fine Motor		
During first part of this period develops pincer grip (thumb and forefinger). Reaches for objects with fingers overextended. Practices releasing grasped objects.	Provide pieces of dry cereal, soft fruits, cooked vegetables (any foods baby can mush with gums) for practicing use of pincer grip.	Demonstrate appropriate toys. Make and demonstrate crayon disk, see supplement, Things to Do for Baby and You. Encourage participants to check with relatives and friends with older children for old used crayons.
Can pick up string and other minute objects.	Provide string and other fine objects for baby to practice this skill, but only when closely supervised to avoid possibility of baby placing anything dangerous in his mouth.	
May bang together two objects being held in each hand.	Provide baby with a bucket/can with items such as large wooden beads, plastic hair rollers, spools, clothes pins, etc., to take out and put back.	
By end of this period, may make scribbling marks with crayons on paper	Tape large sheets of paper on high chair tray or low table, give baby one large crayon or crayon disk (see Things To Do For Baby and You.)	
Place food on spoon with fingers, hold and bring spoon to mouth.		

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Point with index finger.		
Untie shoe laces, pull off socks.	When dressing or undressing baby, encourage baby to help.	
Manipulate pots and pans with lids, nesting and stacking items.		
Play clapping games with all the movements.	Play Pat-a-Cake.	

SOCIAL/EMOTIONAL DEVELOPMENT

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
This period is characterized by the baby's ability to differentiate persons and the dawning of a sense of self. A solid attachment to parent is now evident (as opposed to a biological recognition in the first half year of life.)	Parents need to be sensitive to baby's first 'love affair' which may make him seem overly demanding. Enjoy the baby's physical passion for them (attached parent). Don't be afraid of spoiling him by allowing him to stay close.	For further discussion how this might affect parent/child interaction, see Building on Behaviors and Nurturing Relationships - 6 to 14 Months.
In addition to the traits discussed previously, (Building on Behaviors and Nurturing Relationships, 3 Months to 6 Months, Stranger Anxiety and Separation Anxiety) Safe Base Exploration begins. As the baby becomes more mobile, he will venture further and further away from mother (attached person) into strange territory, sometimes out of sight, to explore, making frequent trips back or vocalizing a need for response, in order to establish that his security base is still there.	Parents must assure baby that they will stay where the baby left them and listen for the baby's vocal attempts to get them to respond, in order for the baby to auditorily locate them. Begin with simple hiding games, e.g., parent behind a chair saying, "Here I am" and showing self, to changing rooms while baby is exploring, but letting baby know where to find parent by locating parent's voice.	
Progresses from smiling at a mirror image at the beginning of this period to reaching and patting image to perhaps kissing or mouthing it.	Place a mirror at baby's level or lift baby to play with him in front of mirror often.	Point out that mirror placed at child's level is important throughout childhood. Locate places where participants may purchase plastic mirrors reasonably.

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
		Brainstorm best location for mirror in their particular environment so it will continue to be useful.
At first tries to imitate facial expressions, later becomes rather good at it. Begins to mimic mouth and jaw movements at 8-9 months. Towards the end of this period may 'perform' for a familiar audience, often repeating act if applauded.	Play "make-a-face" game. Be a willing and enthusiastic audience for baby's antics as this will strengthen feelings of self-worth. Provide dramatic play props; telephone, hats, dolls, purses, etc.	
Calls parents for help, eventually directs (knows how to use) parents as to how they may help him.		
At the beginning of this period indicates a desire to be part of a social interaction, later on may imitate the social interaction (more overtly than he did the first 6 months).	Be sensitive to baby's cues.	Suggest parents observe how their baby lets them know when he wants to participate socially (what tricks does he use?). Have a sharing time, "Baby Hams" could be the topic.
Towards the middle of this period becomes sensitive to people's moods, and is aware of social approval and disapproval.	Adults should use the baby's ability to recognize and act on other people's moods by being consistent in their behavior around him.	
Usually obeys commands; would rather receive approval than disapproval, is not always cooperative; may even begin to tease parent and test limits.	Important that parent view the baby as someone who is just beginning to learn about self and his influence on others. This is but the beginning of a long process for him of sorting out all of that which goes into becoming a social being.	Because it is at this phase of baby's life that parents usually become especially concerned about their baby's social acceptability they have a tendency to feel that they must "teach" and he has to "learn" all the do's and dont's, right now. It might therefore

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
		be wise to refer to "Characteristics of the Well Developed 3 Year Old" to stress the fact that the baby will spend the next two years learning and practicing the social skills which the chart shows the average baby to have developed by three years of age and that in most instances they need every bit of that time.

COGNITIVE/LANGUAGE DEVELOPMENT

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Object Permanence		
This notion develops gradually. At first the baby is not aware that an object exists at all, when he no longer sees it. Next he is able to find it when he sees it partially hidden. Finally he is able to find it when he sees the whole thing hidden, and will soon search for objects he has seen hidden in various locations. By end of this period he will actively search for objects even if he hasn't seen them hidden based on memory of where they were last seen. Unwraps toys, searches in pockets, etc.	Hide a toy under a blanket or behind a screen, partially at first, then all of it as he learns to look for it. Play all kinds of hiding games. Wrap up toys for the baby to unwrap, place toys inside boxes or a totebag for baby to find.	Suggest that participants who have babies this age play these hiding games with the baby in order to observe the step-by-step unfolding of his ability to grasp the understanding of objects permanence. Demonstrate steps.
Continues to explore the properties of items by feeling, tasting, smelling, looking at, visually comparing objects, and listening to anything within reach that he can shake, bang and grasp. May use one hand as holder, the other as explorer.	Give the baby a variety of household items to explore/experiment with, e.g., wooden spoon to bang on different surfaces such as sauce pans, plastic bowls, a cereal box, etc. Fill several sturdy containers, such as empty spice boxes or film cans with small amount of cereal. Leave others empty, tape tops securely, let baby discover which ones make noise.	Demonstrate or provide items for participants to "play" with. Ask them to pretend they are somewhere between 6 and 14 months and to work with those items as a baby would. Afterwards discuss what they learned. (Different surfaces make different sounds etc.)

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Problem solving skills develop at this time. When a child is holding objects in both hands and wishes to pick up a third object, he will usually drop one of the things he is holding and pick up the third object. By the end of this period he will place one of the original objects in his mouth or under an arm in order to retrieve the third object.	Give baby three equally interesting items to investigate.	
At beginning of this period baby may remember a small series of actions of the immediate past if he has been involved, e.g., at 9-10 months old may remember a game participated in from the previous day. By the end of this period, he will be able to remember a small series of actions independent of his own actions.	Play Pat-a-Cake or invent games where adult does something, baby does something in a certain sequence. Baby will prefer games he remembers.	Games Babies Play, Beyond Peek-A-Boo and Pat-A-Cake, Every Day Can Be a Rainy Day For a Baby, see Bib. p. 218 & 219.
Can point to some body parts; shows interest in body parts.		
By the end of this period may begin to explore different ways to obtain goals, such as pushing small chair for support when learning to walk, etc., or removing a cover in order to get to the contents of a container.	Place toys in a see-through box (plastic shoe box). Let the baby try to take the cover off himself. At first adult may take the cover half off.	
Associates properties and events with things, e.g., points to the sky at the sound of a plane, waves "bye-bye" at sight of jacket and and hat, etc., towards the end of this period.	Help baby become aware of his environment's properties by taking him to the window to look for the plane, fire engine, dog, etc., when those sounds are apparent.	

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Language		
At 6 months of age baby babbles, enjoys feeling and listening to his own vocal repetitions of "ba ba" or "me me me."	Imitate the baby's babbling; also leave him time to reinforce his own babbling when he is in the mood. Imitate his other actions such as smiles, scowls, banging on the table with toy or spoon, hand clapping, etc.	
Baby gradually adds more syllables and begins to experiment with inflections, makes sounds as if he is asking a question or making a command.		
By the middle of this period he has a fair amount of receptive language skills, e.g., can understand many words and phrases partly due to word recognition and partly based on his ability to read voice and body gestures.	Be sure to use clear descriptive language: say "Where did the red ball go?" instead of "Where did it go?"	Speaking in specific terms is often something adults don't habitually do. Set up a practice session for participants where in pairs one is the parent talking to the other who plays the role of the baby. Provide a variety of props (the toys used in earlier demonstrations).The 'parent' is to practice using descriptive and accurate labels for shape, color, size, texture, location, volume (sound) mood, etc., rather than speaking in generalities.
By end of first year he can follow simple directions such as "Come here," "Sit down," etc.		
Some babies may say their first meaningful word somewhere between nine months and 18 months.	Show enthusiasm over his new accomplishment; don't, however, push baby to talk or insist that he perform for strangers.	
	To reinforce good speech, when baby begins to say real words, adult should change from imitating baby's actual sounds to repeating what baby attempted to say in correct form, e.g., when baby says "Er-es-da?" repeat "Where is daddy?"	

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
First words are often used to express whole thoughts or sentences such as "Go" may mean "I want to go out." or "Go?" may mean, "Where did the dog go?", etc.	Try to understand his one word sentences by placing them in the context of what he seems to be interested in at the time. Baby will understand and learn words better when adults combine appropriate gestures to match the words. Don't respond to <u>only</u> gestures from him as that may teach him all he has to do is grunt and point to get what he wants.	
Babies continue to learn language from experiencing language; but may appear to lose interest in practicing their language skills for certain periods when they may be especially intent on some other phase of their developmental growth such as the high gear gross motor activity coming up.	Do finger plays and clapping games with baby. Play talking on the telephone. Name body parts, his, yours, the dog's; and of people and animals in books and magazines. Name familiar toys. Identify actions while doing them, but most of all, <u>listen</u> to what he has to say. Encourage his listening skills by drawing attention to all kinds of sounds, i.e., vacuum cleaner, door bell, telephone ringing, etc., and dancing to or tapping out the beat to music on the radio.	
<u>Cognitive</u> Progressses from recognizing self in mirror at some time during the first of this period to possibly reaching for mirror images of objects by the end of this period.		Stress to class participants that this period of development is basically a learning to learn phase; although part of the baby's task continues to be learning the characteristics of materials.

BUILDING ON BEHAVIORS AND NURTURING RELATIONSHIPS

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES

Behavioral Considerations of Adults and Babies

NOTE: To introduce this section the instructor will need to stress to the parents that the relationships with their baby beginning the last quarter of this first year may be in for some stressful changes for both of them. As baby's ever-increasing motor skills enable him to satisfy his thirst to explore and learn, the parents will become more and more concerned for his safety and the safety of their material goods. It is, therefore, important that they analyze their own situation and work out ways that will provide the baby the freedom to explore without their constant anxiety over the safety of their baby and their furnishings. When parents are overly concerned about the latter, the solution often is to banish the child to a play pen or otherwise penning him in. The following quote from Burton White's book, The First Three Years of Life, stresses the inadvisability of this practice.

> ". . . we have found that in families where children are developing very well, restrictive devices are rarely used. In families where children are developing rather poorly restrictive devices play a relatively prominent role."

To help parents evaluate their's and their baby's predicament beginning at this time and to help them actively work out some acceptable solutions, do the following exercise.

Everyday Objects That Create Problems Between Parents and Babies Often Are:

Object	How Parent Values It	How Baby Values It	Appropriate Action (Resolution)
Television set	Expensive, entertaining when watched and listened to.	Has interesting knobs that turn and sometimes come off, or buttons that cause interesting visuals elsewhere (is there a connection)? Checking it out always gets me attention.	

Begin a list similar to the one at left, then, either as a group or as individual assignments, brainstorm all the trouble spots and evaluate them from parent's point of view and baby's point of view. Finally, add a third column, Appropriate Action, listing the best

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION		TEACHING SUGGESTIONS & RESOURCES
Object	How Parent Values It	How Baby Values It	Appropriate Action (Resolution)
New coffee table	Expensive. Has to last a long time. Has sharp corners. Can hurt baby, can cause doctor bills.	Easy to stand by. Good to climb on. Makes different sounds when banged on by small truck, shoe, small block, etc. Checking it out always gets me attention.	course of action for parents to take in relation to each. See "Disciplining the Infant and Toddler", p. 192. for guidelines. Also review the baby's developmental characteristics and needs and the health and safety issues that play a role at this time.
Knick-knacks	They decorate the living room. Will help teach the baby he can't have everything. I've been collecting them since I was ten. They are precious to me.	They are so interesting to feel and taste and look at. They are just like the stuffed (animals) in my bucket. But when I play with them I get yelled at. When I play with the ones in my bucket, no one pays any attention. These are special. They get me attention.	The instructor may wish to combine this exercise with the discussion on "Special Safety Concerns as the Baby Grows Into the Second Year", p. 163.
Lamp on the end table	Irreplaceable antique wedding gift from Aunt Harriet. Would be ostracized from family if anything happened to it.	Has a colorful, neat-to-feel fringe. It jiggles when I touch it. Has a button to feel and push. Part of it lights up at times. (That seems to have something to do with fooling around with the button). Checking it out always gets me attention.	
Toilet bowl	A wonderful place to dispose of waste. Is filthy and full of germs.	Just the right size to pull up and stand by. Feels good to put my fingers in. Things	

Object	How Parent Values It	How Baby Values It	Appropriate Action (Resolution)
		change when I dunk them. Has a neat hingy thing that I can flip and bang. I always get attention when I play there.	

Other Irresistibles:

- toilet paper
- cupboard doors and other doors
- wrought iron bannisters (around stairwells in split level houses)
- range
- drawers
- pet food and water dishes; litter box
- potted plants
- telephone
- garbage cans, wastebaskets

Restrictive Devices vs. Baby's Safety

Playpens. Used regularly they limit baby's need to explore and learn, stifle his basic curiosity and interest in learning.	Parent, under certain circumstances, may place baby in a playpen for very brief periods, e.g., for five minutes while tending to laundry, taking out the garbage, etc., as a baby at this age should never be left on the floor alone in a room.

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Gates. Used at tops of stairways and three steps up from the bottom of stairs are a good idea until baby is capable of negotiating stairs. Not to be used to block off rooms and limit baby's exploring area.	Teach baby to negotiate stairs as soon as possible by letting him practice on a few steps. Safety proof rooms to allow him to learn from the rich environment of the whole home, (except the bathroom). Remember, this is also the period when he is most fearful of being left by the parent. Gates and playpens which restrict his ability to keep track of attached person will cause him to be even more anxious.	
Appropriate Harnesses. Should always be used when baby is on any elevated surface or in a car seat.	Babies are programmed to explore and to develop the use of their bodies, therefore, every effort should be made to limit occasions and duration of times that they need to be restrained to a minimum. When this isn't possible, take advantage of baby's other interests, e.g., interesting toys to manipulate, different sounds to listen to, playing games such as Peek-a-Boo, This Little Piggy, etc.	
Some Specific (Perceived) Behavior Problems		
Getting Into Everything Babies learn by experiencing the world through their senses and their actions. They are motivated by a curiosity which reaches a peak during this period.	Keep in mind that this beginning of a "getting into everything" period is the sign of a well-developing child who is eager to learn about the world. The baby relies on the parent to be there as 1) designer of his world, 2) consultant, 3) limit setter, and 4) model.	

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Crying Although babies cry somewhat less during the second half of the first year, they may be crying more for other reasons due to their developing emotional and intellectual capacities. The baby now often cries from what seems to be irrational fears, e.g., sound of the vacuum cleaner, having certain clothing pulled over his head, etc. Also, often cries when experiencing the unexpected, helplessness, a sense of danger or frustration.	Recognize the baby's crying as his signal for needing help. His feelings are real, even if his reasons for having them seem silly to an adult. Avoid situations that might cause him extreme trauma or help him resolve his fear, anger, etc., with your support. When babies have been pacified with a bottle, such as at bed time, weaning becomes especially difficult. It is therefore recommended that this practice not be started.	Have participants think of situations that a baby at this age may be thrust into, that causes them to cry for no apparent reason, but which is understandable when adult attempts to see it from the baby's point of view.
Stubbornness Some babies, as part of becoming aware of themselves as individuals, will begin to assert themselves, expressing their wants and desires in no uncertain terms during this period. But more often their seeming stubbornness stems from their need to learn something through repetition. Repetition is a very valuable tool for learning and teaching and should not be confused with stubbornness as when it is used in its 'obstinate' connotation.	When the baby repeatedly goes back to playing with the TV knobs he probably has several goals in mind. These are to find out 1) Will they still turn, etc.? 2) Will my parents still come and get me? The parent can help the baby learn the answers by being consistent in his action, e.g., calmly removing the child or distracting him with something else each time he goes for the TV knobs. He soon decides there are more interesting ways to spend his time.	

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Says "No!"		
"No" is often one of the first words babies learn to understand (in a limited sense) and to verbalize. They will practice testing its meaning and simply saying it through constant repetition in the same way they learn any other new word or skill.	Use the word 'no' with the baby to a limited degree. Choose three or four items that will be off limits (deserving of a 'no') and consistently reinforce those limits, until he remembers which ones they are. Remember when he says 'no' to someone he is simply repeating what he has heard and is trying to figure out the impact he will have by using it. Parents will only increase his use of it (or as time goes on) any other word they feel is unacceptable from baby by paying it a great deal of attention.	
Genitalia Play		
It is normal for babies between the ages of 7 months to 11 months to discover their genitals, much as they have discovered their hands, feet, eyes, nose, mouth, etc.	The comfort and pleasure that parents have provided baby through cuddling, hugging, and loving him helps the baby explore his own body and discover the pleasurable sensations of touching himself. Parents should not try to stop this early genital play nor be concerned about it. Rather, they should see it as a sign of normal development. When parents react to the baby's sexual curiosity and exploration with disapproval, they are teaching the baby to associate sex with shame and guilt, and that there are parts of him that are somehow bad.	For parents who are interested in pursuing this subject further a good resource is: "Teaching Your Children About Sex" by Francine Klagsburn, Family Circle Magazine, July 1, 1981.

HEALTH CONCERNS

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Special Safety Concerns as the Baby Grows Into the Second Year		
As baby learns to sit by himself and doesn't want to leave his bath or pool, don't be tempted to leave him alone, even for a second.		Discuss with class the importance of balancing freedom for baby to explore using his body and mind with that of providing for his safety.
As the baby begins to explore, keep areas free of chokables, contaminated food and excreta from humans or pets.		Have each participant reflect on what they have noticed about different parenting styles and how others have handled this age of the first time adventurer. Have them brainstorm and list on the board all things to be mindful of from 1) safety point of view, and 2) developmental point of view.
Parent should wash hands scrupulously after going to the bathroom, changing baby's diapers, cleaning up "accidents" from either the baby or pets.		Suggest to safety proof environment, get down on hands and knees and see it from baby's perspective.
Keep pet food dishes away from baby.		See Health Concerns, 14-24 months)
After incisors have erupted, don't give baby hard foods such as a carrot or celery sticks, unpeeled apples, etc., as he may bit off chunks which he may choke on.		
Teething		
Most babies cut their first lower incisors at around six months, following almost immediately by an incisor on each side. These are followed by the four top incisors. Some babies may have a first molar erupt by the end of this period.	Provide baby with safe, smooth, hard and reasonably clean objects to chew on. After incisors have erupted avoid baby biting nipple by removing it from his mouth when he stops sucking and seems intent on playing instead.	

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Stumbling and Falling This is par for the course for the new navigator.	Prevent some cuts and bruises by arranging furniture with sharp corners and edges away from baby's main routes. When this isn't possible, place edge guards on them. Have safety gates at stairs until baby can navigate stairs safely alone. Remove scatter rugs, place safety door knob covers on doors that are off limits. Let baby go barefoot or dress in soft-soled shoes with good traction. Be prepared for the inevitable bruise by keeping several frozen sponges in freezer to be used as cold packs.	Tell parents where they may purchase edge guards. Recommend that all parents take a First-Aid class or arrange to have a trained first aid instructor talk to the group about the most critical issues for infants and toddlers. The parents may also be interested in learning and practicing resuscitation techniques.
Croup: A viral infection which produces swelling of the voice box (larynx) and major air tubes (trachea, bronchi) that go to the lungs. It can affect children from less than one year to five-six years of age. Signs & Symptoms: Child waking up with hard, painful hacking cough. When he draws his breath to cry, a barking sound results. Breathing is labored and the lower chest will suck in with every breath. Frequently a fever accompanies the croup. Croups last five-seven days and may get worse on the second or third day. It is always worse at night and better during the day.	A physician should always be consulted when croup is suspected. These treatments can be very effective when croup occurs: 1. A vaporizer in the bedroom. This loosens the cough. 2. Provide large amounts of fluid. This will also loosen the cough. 3. When croup is more severe, take child to bathroom, close door, and turn on hot water in shower to produce a warm, moist environment to loosen cough. 4. If still no improvement, take child out into the cool night air for a walk or car ride. This may also loosen the cough.	

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
	5. If child shows no improvement - cannot drink fluids or turns blue at times around lips, bring to hospital emergency room immediately.	
Nutritional Concerns Beginning at the age of six months babies may have vegetables and fruits introduced to their diet; between six months to seven months, juice; and between seven months to nine months, meats.	Some babies are big eaters and may be ready for a three meals a day pattern of solids and bottle or breast at four months. Others may have a small stomach and not be ready until nine months or even later.	Refer to "Recommended Servings Per Day", pp.245 & 246. "Feeding Your Baby With Love" - see Reference Materials p. 266. A recommended instructor reference is the National Research Council's Recommended Dietary Allowances; see Nutrition Bibliography p.268.
From Strained Foods to Rougher Textures Baby can and will decide when he is ready if he is given opportunity to explore different textures from time to time. Babies can mash soft foods with their gums.	Present baby's food with eye appeal. Let eating be fun; tolerate his desire to feed himself. View mealtime as a time for growth and independence. Deal with the mess by covering him with a good bib and the floor with newspapers; have a wet washcloth handy.	
When Should Weaning Take Place? When the baby finds that what is offered instead of the bottle is providing equal enjoyment and satisfaction, he will gradually give up bottles, one at a time, usually staying with the evening bottle the longest.	Don't rush changing textures or weaning from breast or bottle. Be sensitive to your baby's particular needs, e.g., sucking, wanting to do things for himself, etc.	

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Children into their second year should not be allowed to drink milk or iron fortified formula to the exclusion of other foods providing essential nutrients not supplied by milk. Bottle feeding has a tendency to increase milk consumption.		
Finger Foods		
These begin to be an important part of baby's nutritional as well as developmental component at this time.	Let baby feed himself pieces of banana, cooked fruits, cooked vegetables, toast, crackers, etc.	

PHYSICAL DEVELOPMENT

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Gross Motor Most babies have by the beginning of this period mastered creeping, crawling, pulling up into a standing position, cruising, and walking. Next they will practice and elaborate on these skills (may regress to one of the former methods of locomotion temporarily).	Remember that this period is primarily a time for the toddler to refine these previously developed gross motor skills; and he simply runs for the joy of running, kicks for the joy of kicking, and jumps for the joy of jumping. To enhance his good feelings about his new skills pay attention to him and show enthusiasm over his accomplishments.	As a toddler grows physically larger, stronger and speedier, parents often have a difficult time providing appropriate space for him to practice these skills. Have a brainstorming session on good places and ways to provide opportunities to practice his skills, e.g., bringing a large ball along on walks for kicking (not near a street, however), moving coffee table, etc., to clear a safe area, lay a board on the floor to balance on or dance to a record or the radio.
Walking and Running First, toddlers will practice steering, stopping without falling down, negotiating different elevations.		
Next, when the act of walking no longer takes all their concentration, they will begin to incorporate doing other things while walking such as stopping for a toy and carrying it, listening and/or talking to someone, pushing or pulling a toy, etc.	Provide things to hug, tug and drag such as pull toys, laundry baskets, large boxes, small wagons, riding toys, large blocks, pieces of wood, climbing gyms, low balance beams, balls of different sizes.	
Next, walking backwards, running and jumping, walking up and down stairs using wall or handrail. By 24 months of age, they can chase and be chased, stop and start suddenly, dodge and kick.	Be understanding of his desire to be in control of himself in relation to his ability to escape control by others; also of his sense of humor and excitement which he combines with his new 'escape skill' into a form of social teasing game with the adult.	

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
By two years of age a toddler can walk up to two miles at a time, but only when he is psychologically ready.	Go on walks to the park, to the store, up the sidewalk. Let him push the wagon or stroller (if one was brought along). Let him stop and explore along the way.	
Fine Motor		
Can use pincer grasp to purposefully pick up and drop small objects.	Provide a small container and some raisins, cereal or cooked peas for baby to practice with.	
Stacking small blocks into ever increasing taller towers--a feat requiring muscular precision and eye-hand coordination.	Provide blocks or cans for stacking.	
Can perform sustained grasping skills in the use of tools such as spoon, toothbrush, crayon, paint brush, scissors, hammer, screw-driver, etc.		
Then acts on materials with tool in order to have an effect with them. For example, during the first part of this period toddler will spontaneously scribble with crayon on paper. By 18 months, he has developed enough control to draw lines, as opposed to just making marks, and by the end of this period, he can draw crude circles.		Encourage parents to date and save a random sampling of toddler's scribbles. Over a period of time they will notice definite changes from the very simple scribble (mark) to more complex lines and configurations. Share with them that studies of children all over the world show children go through the same progression of scribble patterns.
Practices fine motor skills by digging, screwing, unscrewing, sorting and fitting objects and shapes, stacking, building,	Provide toddler with sandbox, bean/rice table, lacing cards, giant bolts and nuts, small blocks, work-bench, water play, small cars and	

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
filling and dumping, mushing and squishing.	animals, simple puzzles, finger paints, washable markers, paint on the sidewalk with water and paint brush, play dough and clay.	
Doing motions to finger plays.	Practice old and learn new finger plays.	
Sensory Motor		
During the first half of the second year his sensory motor development is characterized by exploring. He systematically moves from object to object looking, tasting, touching, smelling and listening.	Remember that everything is new and interesting to the newly mobile toddler. He notices and is interested in small changes such as a neat stack of diapers on the couch that wasn't there before, a door that is slightly ajar, etc. For his safety and parent's sanity, never assume that there is anything that will not draw his attention.	
In the second half of the second year he goes from being an explorer to becoming an experimenter.	In his quest to learn about objects by looking at them from every angle, he also tries every use and misuse to learn what things are like, e.g., banging a glass to see how it will react. This is not an act of vandalism even though the results may seem so.	
His ongoing experiments teach him that heavy things fall faster than light things, round things roll, square things don't, water makes clothes wet, sand comes off, etc.	He learns by actively trying things out--let him roll balls, oranges, potatoes, blocks, cans, shoes, cars. This is how he establishes in his mind the characteristics an item must possess before it will roll.	Bring a variety of these items to class. Have participants role play being toddlers, playing with these items. Discuss what they, as toddlers, learned about the characteristics of each--how they are different.

SOCIAL/EMOTIONAL DEVELOPMENT

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
This is the beginning of the crucial period of self assertion, as it follows discovering of self awareness.		Ask participants to share their observations of how toddlers they know have shown their self assertiveness.
This period is characterized by an emotional seesaw which has the toddler wanting to be independent and not controlled by adults, on one hand, and wishing to stay a baby and have the security and protection offered by adults, on the other hand.	Parent's role is to stay in the middle and help him keep a balance of his contradictory emotions. To do so: 1. Provide the security of a few simple, clear rules which are consistently enforced. 2. Agree on what the limits are. 3. Provide him with the opportunity to make simple choices--ones that everyone can live with. This will help him develop positive feelings about his autonomy.	For a more thorough coverage of behavior problems related to social/emotional development see Building on Behaviors and Nurturing Relationships.
He has difficulty making choices but insists on making them.	Turning the issue into a game usually gives him an out and allows for a compromise.	
At about 18 to 21 months his struggle for autonomy peaks. He will say "no" just to establish his power, then go along with the request that provoked it. Typically asserts himself by resisting someone else.		

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
The baby is increasingly interested in exploring effects he can have on other people	Parents need to be aware that he is identifying for himself the most effective way of getting attention. Is it by yelling and screaming, poking and hitting, showing off, pulling at, whining, crying or smiling?	
Frustration may lead to tantrums. Besides hitting, screaming, kicking and sometimes head banging during a tantrum the toddler will often react to frustrations by biting (more on biting in Building on Behaviors and Nurturing Relationships).	Eliminate situations that will be frustrating whenever possible. Help him control himself by kindly but firmly holding him. Losing control to this degree is usually very frightening to the baby and he needs adult support to overcome this fear.	
Wants to do things for himself.	When possible let him do as much as he can--don't expect perfection. Plan ahead for the extra time this may take.	
His sense of autonomy is reflected in his attitude towards possessions--me-mine, mine-me. Toys are a symbol of his autonomy and his power.	Parent needs to understand that when their child protects belongings he is trying to protect his sense of power. He will gradually learn that he can let another child play with a toy and still have a right to it, but he is not ready to share yet.	Show samples of inexpensive toys that parents can have on hand for cooperative toddler play--such as buckets full of plastic hair rollers, sturdy boxes, crayons all the same color, etc.
Toward the end of this time period he progresses by using his language skills to assert himself and to manipulate people. Words like "I don't want to" often take the place of or are used with temper tantrums.	As in other areas of development where the toddler is encouraged to use his language skills, it is important that he be encouraged to use them to express his feelings honestly, and be allowed a right to those feelings.	
Is bossy.	This is the toddler's ways of using adults as resources.	

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Is upset when scolded or criticized.	Even though he seems defiant, his feelings are hurt. His body may be small, but his feelings are as real and pronounced as anyone's.	
His fear of strangers usually peaks at about 18 months. Other fears may also begin.	Parents hold and comfort him when his world falls apart.	
He is also sociable and fun-loving. Favorite social games (usually between toddler and parents) are: - investigating parent's face - handing things back and forth - running in place or chasing - teasing/showing off	Pick up on his games and play them with him. Continue to play old favorites and add new ones that will challenge his growing abilities in language, physical dexterity and social skills.	
Returns affection by planting big, wet kisses on favorite adults and family members.		

COGNITIVE/LANGUAGE DEVELOPMENT

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Cognitive		
Is very literal and 'now' minded.	Operates on everything as he perceives it.	
Attention span of 1-2 minutes.	Parents have to constantly remind themselves that these characteristics of the toddler make him vulnerable to acts that they would 'never dream' that he would do, e.g., "He fell off the dock at the cabin, therefore, he won't fall in the pool at grandma's"--WRONG--	Ask participants to think of other situations where the toddler's literal mindedness demands that they approach him differently than they would an older child or an adult.
Short memory, consequently unable to anticipate.	1. He may no longer remember falling off the dock at the cabin;	
Egocentricity rules. He cannot put himself in another's place.	2. If he does, he is still incapable of associating the danger he was in at the dock with the potential danger of the pool.	
Learns through imitation.	3. His sense of fear, should he have one, in relation to either situation, will have nothing to do with the adult's fear--drowning.	
At approximately 18 months of age, he enters the preoperational stage, e.g., can use images and words to represent objects and actions.		
Beginning ability to conceptualize groups identities (stuffed animals are toys and live ones are not, etc.).		
Language		
Although some toddlers seem to ignore their language development during this period of accelerated physical development, they are nevertheless taking in language and preparing themselves to use it.	Things about toddler language development parents should keep in mind:	
	1. Some toddlers talk in full sentences by two years of age, others may not speak at all and still be developing normally.	

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES

Typically he can at some time between 12 and 18 months:

- say four to six different words
- get someone to understand what he wants by pointing and saying a few words.
- can understand words and phrases when gestures are used
- recognizes the names of most common objects in his home
- points to the correct body part when asked"Where is your _____?"
- uses name of familiar things such as cup, spoon, ball, water, etc.
- uses "No"
- Uses "Hi" and "Bye-bye" at appropriate times
- parrots some words that adult says
- listens to interesting sounds, songs, rhymes

In addition, by 24 months he may:

- put together words that express two or more ideas, such as "Me outside."
- has a speaking vocabulary of 20 or more words
- uses gestures but relies more on words to get his ideas and feelings across
- uses some pronouns, such as "mine, me, you"

2. A toddler may need to hear a word repeated often and over a period of time before he tries to imitate it.
3. A child does not really know a word until he also knows what it represents. He needs adults to label and describe their activities together. Each time he has a new experience, give him a new word or short phrase that fits (Parallel Talk). When the parent is busy doing something, he should say out loud what he is doing, seeing, hearing, feeling (Self Talk).
4. Never correct or criticize the toddler's attempts at words or sentences, simply repeat them correctly to let him know he was understood and to tell him the right way to say it. Be a good role model.
5. Jargon is the result of the toddler's attempt to talk as fast as his parents while still lacking the memory for words and the muscle control required to make difficult sounds as well as those used to talk at a fast rate. Jargon usually disappears by two-and-one-half.
6. This is a good time for him to learn standard words for body parts and functions.
7. Go places with him--talk to him about it before going, while there, and after it's over, to help him remember new words and concepts.

Teach Your Child To Talk, see Bib. p. 220, for suggested language activities. (Appendix contains useful sections on early recognition of speech and language problems, a glossary of terms, speech sounds and suggested resources).

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
- enjoys playing 'naming things games. - tries to express his physical needs - uses words to describe things and ask for things - enjoys listening to stories, especially familiar ones - asks "What's that?" - follows single directions, such as "Pick up the ball." - points to the appropriate pictures (of familiar objects) when asked "Show me . . ."	8. Use simple, clear, slow speech when talking to toddler. 9. Begin with useful words, such as family names, food, toys, body parts, clothing, etc. 10. Include the toddler in daily activities so he will feel like a participant not just an observer. 11. Talk <u>with</u> him and listen to what he has to say even if it is difficult to understand him. 12. Expand on his sentences by one or two words, i.e., "up"--"You want up?" 13. Excellent language development activities and materials are: reading books, doing finger plays, dramatic play, puzzles, picture cards, records, toy telephones, talking toys, ripping and tearing.	

BUILDING ON BEHAVIORS AND NURTURING RELATIONSHIPS

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Behavioral Considerations of Adults and Babies		
A Matter of Temperaments		
Effects of toddler's and parents' temperamental differences often heighten due to increase in baby's physical, social/emotional and cognitive growth.	Learn to accept that their toddler is unique and has his own temperament. Parents should observe and learn to understand their toddler's temperamental type in order to handle his behavior (developmentally normal, augmented by his personal temperament) appropriately. Keep in mind that they are not responsible for their toddler's temperament. As the adult (reasoning person) in the dyad the parent has the responsibility to try to understand and work with both their own and their toddler's temperament to most effectively build a healthy relationship between themselves and their toddler.	If some parents in the class seem disturbed by personality conflicts, etc.,they seem to have with their babies, the instructor may wish to spend some additional time helping those parents deal with the issue of temperamental differences. Share and discuss "Baby Talk Session IV: Look Mom, I'm Unique!" See participant resource p. 195. Share with participants list of Tensional Outlets, Ilg & Ames Child Behavior From Birth to Ten, see Bib. p. 210.
Fears and Anxieties		
Boys and girls are equally prone to fears and anxieties--whether for reasons real or imagined, the fears are real to the baby.	Recognize toddlers' sense of helplessness, lack of power, inability to control own emotions. Allow them their feelings. Never shame them for showing fear.	Have class participants brainstorm fears their toddlers have shown, fears their parents might have related that they had when they were very young, or fears they have observed in other young children. Discuss.

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Some clues to general anxiety: - more clingy than usual - not getting into everything as much - more intensive sucking on thumb or pacifier or other self-comfort activity - worried by strange people and places - difficulty going to sleep - shows less enthusiasm for his food, wants to be fed	Observe toddler more closely in order to determine what he seems to be anxious or fearful about. Help him avoid objects of his fears, but do not join him by behaving fearful, too. Baby him, if that seems to help lessen his fears and anxieties. Allow him to use defenses he might have developed against uncomfortable feelings such as sucking a thumb while fingering a favorite blanket, etc.	
Who Has Time to Sleep? The toddler by now is too big to sleep in a portabed, (which made it easy to sleep him away from home,) and too alert and mature not to be distracted by the excitement provided by the world around him. This is often a frustrating time for parents who need the toddler to sleep almost as much as they feel the toddler needs it. Toddlers vary in their need for sleep. Almost all will sleep 11 to 12 hours a night, but a wakeful child may only sleep 20 minutes in the day time, whereas one who requires more sleep may sleep four or more hours during the day.	Come to terms with the inevitable change in sleeping patterns and decide on the best approach for living with them. Some possibilities are: 1. Let toddler get used to irregular hours which will allow him to participate in more adult activities, e.g., go to the movies, dinner at friends, weekend trips, etc., This alleviates being tied down or the reliance on child care help; but may cause the child to have difficulty taking regular naps or going to sleep at night when adults are up. 2. Begin or continue a regular routine of naptimes and bedtimes, following a ritual that helps the child prepare	Brainstorm the kind of routines that seem to work well for getting toddlers to sleep, e.g., reading a story, tucking the toddler in, turning on a soothing record, a few moments gently massaging his back, etc.

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
	for sleep; but be prepared to be tied down to this routine for it to work or be prepared to have a readjustment period if it is disrupted by a family vacation, etc. Parents and their toddlers will be happier if they learn to accept the sleep needs of their particular child and plan accordingly.	
Between 15 and 18 months, most toddlers change from two to one nap a day. The result is often an exhausted, whiny child who doesn't know himself what he wants.	Bear with the toddler as he resists his morning nap but can't quite make it to his afternoon nap, and in general complicates lunch, snacks and nap schedules, until he is able to fully get along with a daily afternoon nap.	
<u>The Overtired Toddler</u> A common problem, especially at this changeover phase, fueled by his need to push himself to his physical limits. Built up excitement and physical exhaustion may result in a tension that makes it difficult for toddler to sleep.	Parents should observe signs of fatigue which are signalled by the toddler when he 1) takes longer than usual to perform a task; 2) seems clumsier than usual; and 3) cries more easily. The toddler doesn't necessarily know he needs to rest so parent must help facilitate a rest or nap.	
<u>Trouble Settling Down for the Night</u> Studies show that at least 50% of the children between ages one and two resist being put to bed.	In order not to give the toddler the message that he and his needs are not important, which he receives when he is left to 'cry it out,' nor to set up the expectation that he really isn't expected to go to sleep, the	

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES

message he gets when he is picked up and brought back into the adult environment, a compromise seems to work best for most toddlers and their parents. It goes something like this:

1. Go through a happy, but quieting, nighttime ritual ending with 'good-night kisses.'
2. Adult leaves, child cries, adult waits a moment. If it is more than a 'test cry,' adult goes back into the room and repeats good night with reassurance that she won't be far away. This may have to be repeated every five minutes until child finally falls asleep, and it may take up to a week before he begins to settle right down. But a week isn't very long when compared with the alternatives which seem to perpetuate a chronic going-to-sleep problem.

Nighttime Waking

Common at this age; causes may be:

- thirsty — Let toddler drink all he needs before bedtime.
- hungry — Be sure he has his dinner before he gets too tired to eat it.
- missing pacifier or other security object — Be sure security objects are close at hand so he can easily find them when he wakes.
- startled by unfamiliar noise — Go to him quickly and reassure him that he is safe.

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
- afraid of dark	Put a night light in his room.	
- chilled from becoming uncovered	Put him in a blanket sleeper.	
- Has nightmares or bad dreams	Go to him quickly and reassure him that he is safe. When he sees the parent's familiar figure and hears a soothing voice and has a few pats on the back, he will go back to sleep in a moment. (When the parent doesn't respond quickly he will become more and more frightened and may require 15 minutes or longer before he is calm enough to go back to sleep.)	
Night Wandering		
Toddlers, by the end of the second year , often decide to go find the parent, go exploring, find something to eat, etc., when they wake up during the night and it can be extremely dangerous.	Parents may avoid this possibility by always dressing the toddler in a blanket sleeper (or cotton bag in hot weather) from early on. If the toddler still persists in climbing out of the crib, it may be time to put his mattress on the floor to avoid any dangerous falls and place a gate at his door to prevent him from wandering throughout house--and indeed, throughout the neighborhood, as some have been known to do.	
The Biter		
Some toddlers deal with their frustrations, get what they want from peers, or simply enjoy 'chomping' on people.	The parent should first of all be aware that it is a rather common problem and one that they will have to deal with much as they will other behavior problems:	When discussing this and other behavior problems, refer to the handout "Disciplining the Infant and Toddler" p. 192.

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
	1. Observe what precipitates the biting and when possible, remove the cause. 2. Help toddler understand that it hurts people when he bites them. If he wants to bite he can bite on an apple or something else that is appropriate. 3. Never bite him back. This only teaches him that it is all right to bite.	
Behavior Problems Associated With Toileting		
Many children, especially boys, around 15 months to two-and-one-half years of age may insist on standing up to have a bowel movement, even though earlier they may have sat on toilet seat.	Works best to let them stand while having bowel movement until they again decide sitting is better.	Stress to the participants that this information is not meant to suggest that children are typically toilet trained at this age, rather that this behavior is typical of children as they are beginning to learn toileting or of the small number who are toilet trained.
Many children between 15 months and 21 months may go through a periodic stool smearing.	This, although messy, is not a serious problem at this age. Try prevention by getting to the toddler as soon as possible after bowel movement, use of more securely fitting diapers, training pants or night clothes.	

NOTE: By now there are, no doubt, parents in the group who are interested in the 'whens' and 'hows' of toilet training. Since the average child is not usually ready for a successful toilet learning experience until the age of 24 months, or later, this topic has not been included as part of the normal development. However, the instructor, in order to help parents prepare for this upcoming task, may wish to introduce this topic at this time. Participant resource, "Toilet Training/Toilet Learning," p.197 may be used as a guide for this discussion. Also, see Toilet Learning: The Picture Book Technique for Children and Parents, and No More Diapers, Bib. p. 220.

HEALTH CONCERNS

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Special Safety Concerns When Dealing with the Explorer/Experimenter Is physically able to get anywhere not secured by adults. Is physically able to take things apart, e.g., unscrew caps on aspirin bottles (even child-proof ones). Does not have ability to anticipate dangers. Learns through imitation, but still lacks control/skills and understanding of consequences of such imitations, e.g., shaving with Dad's razor.		Have participants continue their safety checklist from the 6 month to 14 month stage adding new concerns based on their understanding of how the 14 to 24-month-old operates. (See handout, Accident Prevention and Child Safety, p. 236).
Illness Concerns Greater mobility and close association with other children will increase likeliehood of communicable diseases.		
Bladder infections: Are common in little girls. Little boys rarely get a bladder infection unless there is some underlying problem. Signs and Symptoms: Pain on urination, frequent urination, nighttime urination and occasionally fever. Usually there is pain in the abdomen. Back pain may also occur. The infection may also be without symptoms and found in a routine urine check.	Prevention: Teach little girls to wash with clear water between labial majora and labial minora. After voiding, she should wipe from front to back. - wear cotton underwear - avoid bubble bath - avoid dirty kiddy pools - avoid prolonged contact with wet swim suits	

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
	- drink adequate liquids, especially in summertime. Treatment: Physician will order a medication which must be taken as often and as long as prescribed. It is also important to recheck the urine after treatment to ensure that the infection has been treated satisfactorily. This will prevent longterm problems.	
Strep Throat: A bacterial infection of the throat causing a child to be more sick than when suffering from a viral sore throat. Signs & Symptoms: Glands in child's neck often swollen and tender to the touch, sudden onset of fever, feels tired, may vomit, back of throat bright red and may be covered with white pussy spots, running nose, sneezing and loss of appetitie, and difficulty swallowing.	Parent should bring child to doctor for throat culture and treatment. If strep is found, ten days of antibiotics is required. The parent can make the child more comfortable by providing aspirin for pain, plenty of fluids and rest. Also cold foods or warm drinks may sooth sore throat and warm wet towels placed on swollen neck glands may offer some comfort and relief of throat pain.	
Teething Child will be teething most of this year. May experience discomfort with first molars cut at around 15 months and second set of molars by 24 months. Child may be irritable and miserable for a day or two with each molar.	To ease discomfort, provide child with something cold to bite on--or massage gum gently with finger. Be sympathetic.	
Good dental care: - diet with adequate calcium and vitamin D - fluoridated water - twice daily brushing after molars come in - no bottles of milk or sweet drinks to bed, or sweetened pacifiers	Help child begin a good dental program now by providing tooth brush and good modeling.	

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
Dental accidents: - teeth knocked loose or out	Parent should always consult a dentist when a toddler suffers a traumatic injury to the mouth. Primary teeth removed by traumatic injury should not be replaced. Dental x-rays will be needed to determine exact number and position of remaining teeth. Teeth which have been jarred hard may turn dark.	Check with the dental society in participants' locale for names and telephone numbers of dentists who are willing to take after-hours emergencies.
Nutrition-Related Health Problems		
Anemia: Often caused in the toddler who was weaned from iron-rich formula to whole milk too early. Symptoms: Fatigue, pallor of the skin, mucous membranes, and abnormal blood test.	Prevention: Supply toddler's diet with "red" meats and legumes, whole grain breads and iron fortified cereals and green vegetables.	
Obesity: Often caused when 1) child is cajoled into eating more than he wants; 2) food is used as a substitute for affection or needed attention; 3) child's activity (energy output) does not correlate with his energy intake. Signs of obesity: When weight for stature is greater than or equal to 95th percentile on growth chart and skinfold measurement is excessive. Signs of underweight: When weight for stature is less than or equal to 5th percentile on growth chart.	Have pediatrician or other qualified health professional determine whether toddler is obese and/or whether there are any other physical health problems. If the child is determined to be obese, or underweight with no other illness, observe and document child's eating habits and nutritional intake, and his behavior patterns. Change child's diet and encourage appropriate physical activity for age. Do a self-observation: Do I use food 1) as a reward; 2) to show affection; 3) as a pacifier? Have I determined for the toddler 1) when he has had enough; 2) that	

NORMAL CHARACTERISTICS	PARENT-CHILD INTERACTION	TEACHING SUGGESTIONS & RESOURCES
	his worth is equal to how well he has cleaned up his food? Have I 1) consistently kept nutritional foods on hand; 2) modeled good eating habits by joining him at mealtimes eating what I expect him to eat?	
Nutrition Concerns Is he getting enough to eat? Child's growth rate, beginning at about one year of age, normally slows down to approximately one-half pound gain per month as compared to one pound per month the first six months of life. Causes are: 1) decrease in growth rate and with it a decreased interest in and need for food; and 2) too busy exploring to eat.	Parents must offer a diet that provides calories and nutrients that count because he is still growing and developing, and is increasingly active. Be sure not to offer empty calories via soda pops, potato chips, etc., as they will cheat him of essential nutrients.	
Serving Food to the Toddler Serve food in small portions. Offer unfamiliar/unpopular foods first. Serve milk in 4 to 6 oz. cup filled one-quarter full. Serve one tablespoon per year of age per serving of cooked foods. Offer foods five to six times during the day with at least two to two-and-one-half intervals.	Plan regular meals and snacks including a balance of nutrients from the four food groups. Remember snacks are an important source of nutrients and energy for the toddler and should be planned for as carefully as main meals.	See participant resources "Feeding Milestones For Toddlers" p. 246, and "What Is a Serving?" p. 247.

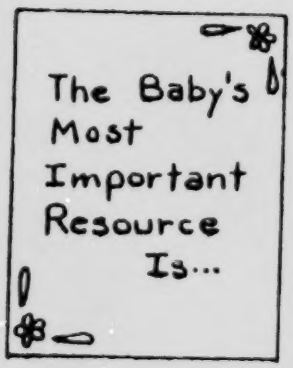
INFANT-TODDLER
GROWTH AND DEVELOPMENT
RESOURCES

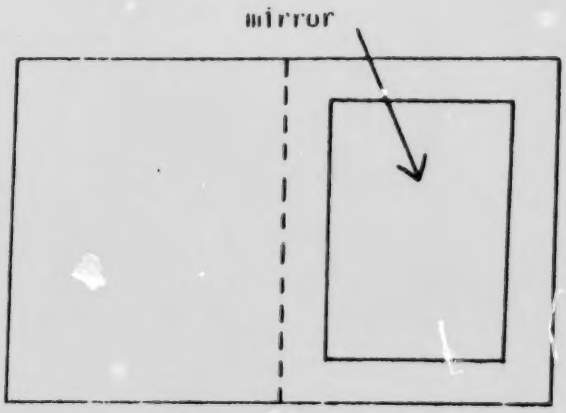
Directions for Making:

THE BABY'S MOST IMPORTANT RESOURCE

To help impress on parents of infants and toddlers that the TLC (Tender Loving Care) they provide is the most important element which will influence healthy growth and development, the following learning aid is useful.

Take a piece of poster board approximately 10" x 17" or any size to fit an available mirror. Fold the poster board in half. On the outside write "The Baby's Most Important Resource Is...." On the inside glue or tape a mirror on the right hand page.





Circulate this at the beginning of a class or workshop on infant-toddler education. If the class has had a great emphasis on toys and activities to stimulate the child, circulate The Baby's Most Important Resource at the end of the session to re-emphasize the importance of the adult-child interaction.

INFANT ASSESSMENT TOOLS

Apgar Scoring System

The Apgar score rates five vital areas: heart rate, respiration, muscle tone, reflexes, and color. Scoring is done at 1 minute, 5 minutes and 15 minutes after delivery, based on the following observations:

Sign	0	1	2
1. Heart rate	Absent	Below 100 per minute	Above 100 per minute
2. Respiration	Absent	Slow irregular	Cry, regular rate
3. Muscle tone	Flaccid	Some flexing of extremities	Active movements
4. Reflex irritability	None	Grimace	Cry
5. Color	Body cyonotic or pale	Body pink, extremeties cyonotic	Body completely pink

The Apgar is not an IQ score, nor is it, as often perceived, a predictor of the baby's future well being. It is simply a test of how he has responded to the immediate stress of delivery and to the readjustment of life outside of the womb. Its main value in the delivery room is that it forces someone to pay close attention to the new baby. A score of 7 or less requires an even closer observation.

The Brazelton Neonatal Behavioral Assessment Scale

The goal of the Brazelton Neonatal Behavioral Assessment Scale according to Dr. Brazelton who developed it and who co-authored Newborn Behavioral Assessment, "is to capture the newborn's rich behavioral repertoire in a systematic way."[1]

The exam takes approximately 20 minutes, and is performed in a semi-dark room. The examiner, using only a flashlight, bell, rattle and safety pin, elicits "the baby's best performance,"[1] through 25 to 30 different maneuvers.

The BNBAS focuses primarily on:

1. The infant's competence in organizing his or her "state" (see So, What Are The Baby's "States?", p.275).
2. The newborn's ability to habituate, i.e., effectively shut out auditory, visual and tactile stimulation during sleep or drowsiness.
3. The baby's ability to interact with his environment.
4. The baby's responsiveness to animate stimulation, such as, cuddling, voice, face, etc.

[1]Children Today, Vol. 10, No. 4 July-August 1981.

The rest of the exam notes the newborn's physiological reactions to the stress of the exam.

Although the BNBAS was designed primarily as a clinical tool to help predict longterm effects on the nervous system resulting from perinatal trauma, it has also been, and is, increasingly being used as a tool to assess the infant's role in shaping the evolving parent child relationship, e.g., the way a baby behaves when being tested at 7 days old, can provide some insight to the future impact he will have on his parents or other primary caregivers. It is, for example, felt that parents of babies who at 7 days old test as unresponsive and motorically immature, with poor physical regulation, can be given anticipatory guidance and will, therefore, be better equipped to deal with any possible problems. Another potential use of the BNBAS is as a tool to help parents begin to better individuate to the baby from birth. As they observe their baby during the testing, they become more sensitized to his abilities and development, and as a result provide more appropriate stimulation for their baby which in turn elicits more reinforcing social behavior from the baby.

Denver Developmental Screening Test

This is an assessment tool commonly used in clinics, and by programs such as Head Start. It is an individually administered, norm-referenced early identification tool designed for children birth to six years of age. It takes approximately 20 minutes to give, score and interpret and covers 105 skills which are clustered into the following general developmental areas.

1. personal-social development
2. fine motor development
3. language development
4. gross motor development

Two types of scores are used. (1) Delay; a delay is scored if a child fails an item that is passed by 90% of the children that are younger. (2) Normal or abnormal; abnormal is scored when the child has two delays in each of two areas.

Parents should be cautioned that the test is a gross screening of delayed development and it must be followed by a more intensive evaluation before conclusions may be determined.

Early and Periodic Screening Diagnosis and Treatment

A screening service designed to check on a child's total growth, e.g., vision, hearing, physical growth, nutritional status, developmental status and immunization status. After initial screening at birth EPSDT screening is recommended periodically: 6 months, 9 months, 1 year, 18 months, 2 years, 3 years and every three years thereafter.

The primary purpose of the EPSDT is to be able to catch and treat any potential total growth problems as early as possible. Parents should view it as a tool to help them adjust the care of their child to the child's needs.

The service is provided in many communities through private physicians and EPS programs conducted by community Health Service Agencies. The Medicaid-eligible may receive services without charge and the non-M.A. eligible child is served on a sliding fee schedule by EPS programs. For further information contact the local County Social Service or Community Health Service Agency.

DISCIPLINING THE INFANT AND TODDLER

When we discuss discipline of infants and toddlers we must recognize that we are talking about our influence on the very foundation of the child's social development. Even though factors such as heredity, and physical and emotional characteristics play a role in this development, our ability to understand and adapt to these characteristics and to the normal growth characteristics of young children plays an equally important role.

First, you may want to look at your goals. What sort of things do you hope your three year old will have going for him as he leaves infancy and toddlerhood? Studies show that people who seem to get along well, socially and otherwise, had the following characteristics in common at age 3.

They had the ability to get the attention of adults and were able to keep their attention.

They were able to use adults as a place to go for help and support.

They were able to show their feelings to adults, whether feelings of affection or anger.

They had the ability to be either leaders or followers when playing with children their own age.

They were able to show feelings of affection as well as anger to their age mates.

They were able to compete.

They were able to show pride in themselves and in their own accomplishments.

They were able to pretend and to act out roles. Also, they had the ability to guess how someone else might feel or were able to see a situation as another person might see it.

They were able to understand when spoken to and to make themselves understood through use of language.

They could anticipate consequences or figure out ahead of time what the result of certain actions might be.

They were able to feel when things were't quite right or when things were not in harmony.

They could deal with abstractions and make interesting associations.

They could plan and carry out activities that required several steps.

They were inventive in their use of materials.

They were able to pay attention to several things at once.

You will also need to consider some developmental factors involved in infant/toddler learning. Following are some of the characteristics that need to be kept in mind for 0 - 3 year olds.

They learn through their senses - by exploring and experimenting.

They learn from the example of others and from feedback they receive from others about their behavior and abilities. They also learn from the results of their own actions and experimentations.

Anywhere from 6 to 22 months of age they go through a normal phase of being afraid of strangers (stranger anxiety). They will also go through a similar phase of being afraid of being left by their primary caregiver (separation anxiety).

Sometime after 14 months of age an awareness of themselves begins. This starts a normal phase of development commonly referred to as 'negativism.' This may come early, 14 months or so, and leave early; or come on late and leave late, but is normally over by age 3.

Also, they are extremely curious - they have short memories - they have limited experience upon which to base decisions - they may know words but do not fully understand their total meaning - they are physically underdeveloped - they must move - and, they all need attention.

Next let us see how we can best help the infant and toddler develop into a three year old who has the ability to control himself, who has a good feeling about himself, who is considerate of others, and who, in general, has the abilities discussed in the beginning. To do so it helps to keep in mind the following.

1. Be consistent. Infants and toddlers have short memories, but they will learn through repetition.
2. Respond positively to behavior you like and want to see the child continue. Children all ages will continue to do whatever gets them the most attention.
3. Set a good example. Young children learn from example, by watching and listening to those around them.
4. Allow children to learn from their own actions. For example, when they throw all their toys out of the fence, they will not have them to play with.
5. Show respect for their rights and abilities. A child whose right to speak is not honored, for instance, will not learn to respect others' rights to speak. It must be kept in mind that young children's size and immaturity in no way takes away from their right to be respected.
6. Each child is unique. The child who is extremely active may need more opportunities to satisfy his need to move through opportunities to play with extra toys and equipment. Whereas a less active child may require extra cuddling. Then again, . . . you might have discovered that for your infant or toddler, just the opposite is true.
7. Help children learn to control themselves. When a toddler has a temper tantrum as a way to relieve his frustrations, help him calm himself down by firmly, but kindly, holding him on your lap with your arms surrounding him as you tell him that you will help him feel better.
8. Help the child learn to understand that it is better to make someone feel good than bad. When the child causes another child to cry because he hit, pinched, etc., have him help comfort the victim by encouraging him to stroke the spot that was hurt all the while explaining that what he did hurt the other child and now he needs to help that child feel better.

9. Give choices only when a child is capable of making them and when you can live with them. Remember the under 3's have limited experiences upon which to make decisions. So give choices that they can practice making decisions with and which say that you can be relied upon.

10. Let him learn about something off-limits under supervision. The child is naturally curious, let him investigate that beautiful candle on the shelf while you hold it and explain that this is not a toy for him to play with but that he can ask you to show it to him again. For a really young child (under a year) such things should be put away.

11. Use your voice as a guidance tool. Use a firm moderate tone when you want to show your displeasure - children prefer to please when that is possible. Your voice lets them know when you are pleased or displeased.

12. Show your child what you want. Your child's language skills are not always as good as they may seem; help him by accompanying your words with action. For example, move him away from an object when you say "No, No."

13. Use positive commands - help the child understand what he should do, not just what he shouldn't do. "Hold the glass with both hands, then the milk won't spill," not "Don't spill the milk."

14. Provide the security of rules and limits that are reasonable, clear and simple. Then evaluate each rule or limit by asking yourself, is this limit ...

    a. Necessary for the child's safety?

    b. Necessary for the safety or well being of others?

    c. Necessary for the protection of property?

    d. Primarily for the convenience of adults?

    e. Restricting a child from trying things, i.e. learning through exploration and experimentation?

    f. One the child has outgrown the need for?

    g. One that can -e reasonably enforced?

15. When someone else is going to care for your child, encourage that person to give your child the attention he needs until he feels secure with this new person and the new environment. Remember that separation anxiety and stranger anxiety are normal fears. Children placed in strange situations and with strangers are not being cry babies or acting spoiled, they simply need time to adjust. This is true for children going through any type of upheaval such as illness, loss, change in home environment and so forth.

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BABY TALK

SESSION IV: LOOK MOM, I'M UNIQUE!

Temperamental Differences

Chess, Thomas and Birch have broken temperament into nine areas. Four of the areas deal with mood, three with energy level and two with consistency. As you read this information, think about where your child falls on the continuum. Remember, you are not responsible for your child's temperament.

1. Initial Response of Approach or Withdrawal
   From complete withdrawal to.....total approach of new situations.
   From distress by the unfamiliar to.....plunging in spontaneously.

2. Adaptability to Change in Routine
   From rigidity in routine to.....flexibility.
   From inability to shift patterns to.....ease in change.

3. Sensory Threshold
   From no reaction to.....intense awareness of noise, light, heat, textures, smells, pain.
   From placid acceptance to.....violent non-acceptance.

4. Prevailing Mood
   From usually fussy, irritable, negative to.....usually contented, accepting, positive.

5. Intensity of Response
   From loud wailing and kicking to.....quiet sobs and pleas.
   From exuberant jumping and yelling to.....quiet smiles and gestures.
   From high expenditure of energy to.....low expenditure of energy.

6. Activity Level
   From body in constant motion to.....body at rest.

7. Distractibility
   From total ability to concentrate to.....distractibility by minor intrusions.

8. Persistence--Attention Span
   From pursuing a goal in the face of huge obstacles to.....quitting when obstacles appear.
   From pursuing an activity until finished to.....leaving an activity often and returning.

9. Regularity
   From predictable patterns in eating, sleeping and elimination to.....no patterns.

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*Baby Talk, 1980. Adult Vocational Parent and Family Education, Minnesota Department of Education. This curriculum available from the Minnesota Curriculum Service Center, 3554 White Bear Ave., White Bear Lake, MN 55110. For further information, Metropolitan Area residents call 770-3943. Outside Metro Area call toll free 800-652-9024.

Chess, Thomas and Birch found particular temperamental types from their study which they named and described. The Difficult Child (10% of their subjects) displays an intense response, withdraws in new situations, adapts slowly, is irregular and possesses a prevailing negative mood.

The Easy Child (40% of their subjects) is predominately positive, approaches new situations easily and is mild in reactions.

The Slow Warmer Upper (15% of their subjects) displays the same negative response to new situations and slow adaptability as the Difficult Child, but his or her responses are milder and less irregular.

TOILET TRAINING/TOILET LEARNING
or "Much to do About Doo-Doos"

Toilet training or "toilet learning" as it is becoming more popularily phrased, is perhaps the effort that most often puts the parent-child-caregiver relationship to its most severe test. This is not surprising since each adult comes to this developmental challenge with different experiences and often different goals. The very phrase, toilet training, will send shivers up and down the backs of some parents, whereas others will simply smile and say, "I find it a fascinating process." Why the different reactions? Chances are, the first group has not discovered some of the secrets that have been working for the second group. Following are some of the Toilet Learning Success Group's toilet training secrets. These people will henceforth be referred to as the TTS:s (Toilet Training Success Persons). In checking out their secrets you may find that you are already part of this group or well into its membership. If not, with time, thought and patience you'll get there.

1. The TTSPs realize that toilet learning begins at birth. It begins when the adult respects the baby's need to feel dry and clean and good. They make the diaper changing time one that is pleasant for both and one that leaves the baby feeling good about all of his/her body and his/her bodily processes. They talk in matter of fact language about the stool, the urine, the penis, the vagina or whatever labels they have decided to use in tneir family. They avoid references to icky, pewie, stinky, etc.

2. They are honest about their own feelings. After a whole day of changing diapers on a 20 month old with diarrhea it is not unusual for one to feel out of sorts. The TTSPs will probably say, "I am sure getting tired of changing all these diapers. I'll bet you're tired of having them too, huh baby?"

3. The TTSPs will make sure the baby, from early toddlerhood, has opportunities to see appropriate toileting practices being modeled by their own sex.

   Dad, "Chad, do you want to go to the bathroom with me?"

   Mom, "Lisa, I'm going to the bathroom. Why don't you come along?"

4. They provide potty chairs that stand securely on the floor (and from which the children can place their feet securely on the floor) for the toddler to practice sitting on long before it is time to actually begin training. This sitting-on-the-potty practice may begin when the child is around 18 months old.

5. They know that every child's muscles and nervous system develop at very different rates. This means that each child's ability to control the muscles used for urination or bowel movements is dependent on the development of his/her central nervous system. Consequently, even the child who can use all "the right words" and knows mentally what "going to the bathroom" is all about, may not be quite ready while another child the same age, whose language skills are still at the pointing-grunting stage, may be so ready he/she trains himself/herself.

6. The TTSPs also watch the child to see <u>when he/she is really interested and when he/she really understands</u>: (a) what they want him/her to do, (b) why they want him/her to do it, and (c) how to do it. At first they may suggest to the child that he/she sit on the potty chair with his/her diapers on, just to get the feel of it. They may also watch for a signal such as a grunt, and then gently lead him/her to the potty chair, telling him/her as they remove his/her diapers, "This is where you make a bowel movement," or whatever phrase they have been using with him/her. They don't overdo this since all they hope to accomplish for the next two or three months is to help him/her understand what he/she is to do there (or what he/she has, most likely, already done).

7. The TTSPs watch for the following signs before they begin toilet training in earnest.

   - The child remains dry for longer and longer periods of time e.g. a couple of hours at a time, dry after naps and upon waking in the morning. (Staying dry all night usually comes after daytime dryness.)
   - The child shows some signs of being aware that he/she needs to empty bowel or bladder.
   - They observe their child to see whether his/her mode of operating lends itself best to (a) sit him/her on the potty at regular intervals i.e. every couple of hours, (b) asking him/her if he/she has to go every now and then, or (c) to wait for him/her to tell them.

8. They use consistent and accurate language.

9. They show pride when the child is successful, but do not go overboard since that will only heighten a child's sense of failure when the inevitable accidents occur.

10. They treat accidents matter of factly with an attitude that they are also part of the toilet learning experience.

11. They label "training pants" as "underpants" or "undershorts". This helps the children relate to the fact that they are growing up and gaining "grownup" skills. When they wear "underpants" they will try hard not to mess them, because the adults whom they look up to don't mess theirs.

12. They dress the child in clothing which he/she can manage easily, such as pants with a comfortable elastic waist, rather than clothing with buttons, belts, suspenders, snaps or hooks.

13. They are aware that this is the first time in their's and their child's relationship that the parent must depend on the child's cooperation to accomplish the parent's goal. Rather than viewing it as a contest of wills, when the child chooses to use his/her veto power, they view it as an educational process in which they are helping the child to take steps to keep himself/herself clean. Once children are physically and psychologically ready, the sense of achievement and pride in their ability to do things for themselves and pleasing the parent usually combine to make the child a cooperating partner in the toilet training/learning venture.

14. They recognize that by waiting until the child is really ready they will have spent approximately the same time on washing or buying diapers as if they started too soon and had the child finally trained only when the child was ready anyway. The former makes for a good experience, the latter creates a stressful experience that often has a negative influence on the child's further emotional development and the adult-child relationship.

INFANT-TODDLER GROWTH AND DEVELOPMENT:

AUDIO-VISUAL RESOURCES*

The following materials are available for preview from the Minnesota Curriculum Center.

AGES AND STAGES: THE DEVELOPMENTAL RELATIONSHIP

Produced by the Minnesota Family Day Care Training Project. Written by Rita Warren.

The presentation focuses on the emotional development of children from infancy through latency. Describes the needs of children at various stages and how they can be met by parents and caregivers.
Approximate running time: 15 minutes.

BRINGING UP CHILDREN A How-To Guide for Parents and Caregivers

Prepared under the supervision of the editors of Parents' Magazine in consultation with Wanda Drapes, Co-director of the Diagnostic Nursery, and Associate Professor of Child Development, Department of Psychiatry and Behavioral Sciences, University of Oklahoma.

The series is designed to familiarize professionals, paraprofessionals, students and parents with the basic needs of infants and young children, and give suggestions about how adults can fulfill those needs.
Approximate running time: 120 minutes. Includes the following titles:

FEEDING TO NOURISH AND LOVE
Breast and Bottle
Solid Foods
The Push to Independence
Feeding Myself
Nutrition and Communication

BATHING, DRESSING AND TOILET TRAINING
Sponge Bathing the Newborn
Tub Bathing and Tooth Brushing
Diapering and Dressing
Toilet Training
Helping Preschoolers Help Themselves

HEALTH CARE
The Wide Range of Normal
Safety for the Growing Child
Caring for the Sick Child
When to Call for Help
Parent, Doctor, and Child

DAY TO DAY WITH YOUR CHILD
The First Three Months
The Infant's Communications
Communicating with the Toddler and Preschooler
Common Problems
Discipline-What Is It?

* For names, addresses and telephone nunbers of Audio-Visual Distributors, see p. 87 .

CHILD DEVELOPMENT & CHILD HEALTH

Prepared under the supervision of the Editors of Parents' Magazine in consultation with Mary B. Hoover, author of The Responsive Parent.

The series is designed to prepare parents-to-be for the responsibilities of caring for the health of the growing child and to offer parents and professionals information about the prevention and treatment of customary childhood health problems. Helping the child with good emotional, intellectual, and physical health. Approximate running time: 120 minutes for entire set. Includes the following titles:

LOVE AND IDENTITY
The Subject is Love
The Need for Attention
Food and Love: Food Understood
Love and Independence
The Oedipal Phase

PLAY AND SELF EXPRESSION
The Importance of Play
Play and Learning About Oneself
Play and Learning About the World
Play and Parent/Child Relationships
Play and Peer Relationships

CONFLICTS BETWEEN PARENTS AND CHILDREN

Prepared under the supervision of the Editors of Parents' Magazine in consultation with Mariann P. Winick, Associate Professor of Education, Lehman College, City University of New York.

The series is designed to encourage parents' understanding of their child's level of development and abilities and to form realistic expectations which the child can fulfill. The emphasis is on both parent and child feeling satisfied and happy as the child begins to learn the valuable lessons of successful behaviors and self-confidence.
Approximate running time: 120 minutes for entire set. Titles include the following:

DAILY DISAGREEMENTS
Toileting Troubles
Dressing Disputes
Bathing Battles
Bedtime Bickering
Mealtime Misunderstandings

PARENTS EXPECT. . . CHILDREN WANT
Desires and Demands
Learning the Rules
Helping At Home
Watching Television
Playing Alone

STRANGE NEW PLACES: LAUGHTER OR TEARS?
Going to the Store
Going to School
Going to the Doctor
Going Travelling
Going on Vacation

FROM ME TO WE: GROWING UP WITH OTHERS
Making Friends
Getting Along
Visiting Other People
Living With Brothers and Sisters
Meeting Relatives

THE FIRST 18 MONTHS: FROM INFANT TO TODDLER

Prepared under the supervision of the Editors of Parents' Magazine. Prepared by Rita Kramer in consultation with Milton I. Levine, M.D. Designed to help adults understand more fully the needs, behavior and development of infant as well as a child's growth from infancy to toddlerhood. Filmstrips 10 min. each.

The New Arrival
Discovering the World
Making Friends with Family
First Steps, First Words
A Time for Adventure

HURRAY FOR ME! Self esteem in Young Children

Produced by the Minnesota Family Day Care Training Project. Written by Rita Warren.

The presentation focuses on early experiences which establish feelings of self-worth or valuelessness in infants and young children. It touches on societal factors in the development of self esteem as well as the roles of parents and caregivers.
Approximate running time: 11 minutes.

The series is available in both slide and cassette tape presentation and filmstrip and cassettes. Also includes is audio script and discussion guide. Two copies of the slide presentation and two copies of the filmstrip presentation are available.

UNDERSTANDING EARLY CHILDHOOD AGES 1 THROUGH 6

Prepared under the supervision of the Editors of Parents' Magazine in consultation with Mrs. Rita Rabinowitz, Training Specialist in Early Life Education.

The series is intended for use by parents, teachers, and those who work with children. Presented is an explanation of what we now know of how children learn, and how parents and others working with children can encourage and guide the young child's learning experiences during his formative years.
Approximate running time: 150 minutes for entire set. Includes the following titles:

THE CHILD'S RELATIONSHIP WITH THE FAMILY
How a Child Sees Himself
Dependence Versus Independence
The Parent is a Teacher
Forcing the Child to Fail
Learning From Our Children

THE CHILD'S POINT OF VIEW
When Fantasy is Reality
The World is Alive
It Happened on Purpose
What's in a Name?
Communication is an Investment

PREPARING THE CHILD FOR LEARNING
How an Infant's Mind Grows
How the Young Child's Mind Grows
How Language Grows
Learning Every Day
Where Can a Young Child Learn?

THE DEVELOPMENT OF FEELINGS IN CHILDREN
How Feelings Grow
How to Deal With Fear
Love and Joy
Anger and Sadness
Expressing Feelings

WHAT DO I SEE WHEN I SEE ME? EMOTIONAL AND SOCIAL GROWTH IN CHILDREN

Prepared under the supervision of the Editors of Parents' Magazine in consultation with Elizabeth S. Hirsch, Associate Professor, School of Education, The City College of the City University of New York.

The series is designed to give professionals, paraprofessionals, students and parents insight into a child's affective development and to give suggestions how adults can encourage the process in the children they care for.
Approximate running time: 120 minutes for entire series. Titles include the following:

I SEE HOPE
What is Affective Development?
Major Milestones
Understanding Affective Development
The Family's Role
Care and Development Outside the Home

I SEE SMILES, I SEE FROWNS
The Importance of Feelings
Pleasure and Love
Fear and Anger
Sadness and Jealousy
Emotional Problems

I SEE STRENGTH
The Importance of Self-Confidence
The Origins of Self-Confidence
Independence and Internal Control
New Situations and Traumas
Self-Confidence and Traumas

I SEE LOVE
Understanding Children's Behavior
Communicating with Very Young Children
Communicating with Preschoolers
Helping Children Relate to Others
Handling Everyday Problems

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The following materials are available from the Department of Public Welfare Library.

AGES AND STAGES - The Developmental Relationship

Describes the emotional development of children from infancy through latency, the needs of children at these various stages, and how these needs can be met by parents and caregivers. Development is a continuum and it is important to be attuned to unmet needs and unresolved issues from earlier development phases. (1976)
79 Color Slides & Cassette Tape.

CHILD PART THREE: DEBBIE & ROBERT, 12-24 months

This film traces the growth and development of two children in their second year of life. We are invited into the homes of Robert and Debbie to observe them as they learn and grow and begin to enter the mainstream of everyday human affairs.
Motion picture, 30 minutes.

DEVELOPMENT OF THE CHILD: INFANCY

This film presents highlights of some of the major psychological processes of the first eighteen months of life. A major theme is that the child is born remarkably mature. He can see, hear and smell, and is sensitive to pain, touch and change in bodily position. The very young infant, from a biological point of view, is prepared to experience the basic sensations of his species. He also is capable of displaying a variety of motor responses, and the film shows the major reflexes of the newborn. (Harper & Row). AVAILABLE ONLY FROM OCTOBER 1 THROUGH APRIL 30.
Color. 20 Minutes.

GROWTH AND DEVELOPMENT: A CHRONICLE OF FOUR CHILDREN

Four healthy, normal children and their families (two black and two white) from a large eastern city were filmed periodically over four years in identical home-like surroundings, and engaged in naturally occurring events typical for the age. Although the filmed events were selected by the authors from many possible activities, each family's response to the infant behavior was spontaneous and unrehearsed. At first filming, two infants were slightly under one month of age; two were approaching the end of the first quartile. This gives the viewer an opportunity to see development at the beginning and end of each developmental stage from infancy to age four. (Lippincott Co.) AVAILABLE ONLY FROM OCTOBER 1 THROUGH APRIL 30.

FINDING A PLACE
3-6 Months Color

MELISSA, 4 months	5 Min.
GREGORY, 3½ Months	5 Min.
TERRA, 5½ Months	5 Min.
JOSEPH, 5½ Months	5 Min.

REACHING FOR REALITY
6-9 Months Color

MELISSA, 7½ Months	5 Min.
GREGORY, 7½ Months	5 Min.
TERRA, 9 Months	5 Min.
JOSEPH, 9 Months	5 Min.

SEARCH FOR PERMANENCE
10-12 Months Color

MELISSA, 10 Months	5 Min.
GREGORY, 10 Months	5 Min.
TERRA, 12 Months	5 Min.
JOSEPH, 12 Months	5 Min.

PRESENCE OF SELF
15-16 Months Color

MELISSA, 15 Months	5 Min.
GREGORY, 15 Months	5 Min.
TERRA, 16 Months	5 Min.
JOSEPH, 16 Months	5 Min.

SEPARATE SELF
2 Years Color

MELISSA, 21 Months	5 Min.
GREGORY, 21 Months	5 Min.
TERRA, 22 Months	5 Min.
JOSEPH, 22 Months	5 Min.

WORLD WITHIN
2½ Years Color

MELISSA, 27 Months	5 Min.
GREGORY, 27 Months	5 Min.
TERRA, 28 Months	5 Min.
JOSEPH, 28 Months	5 Min.

WORLD FROM ONE POINT OF VIEW
3 Years Color

MELISSA, 34 Months	5 Min.
GREGORY, 35 Months	5 Min.
TERRA, 35 Months	5 Min.
JOSEPH, 35 Months	5 Min.

OTHER REALITIES TESTED
3½ Years Color

MELISSA, 40 Months	5 Min.
GREGORY, 40 Months	5 Min.
TERRA, 41 Months	5 Min.
JOSEPH, 41 Months	5 Min.

SELF AND MANY OTHERS
4 Years · Color

MELISSA, 46 Months	5 Min.
GREGORY, 46 Months	5 Min.
TERRA, 47 Months	5 Min.
JOSEPH, 47 Months	5 Min.

HOW AN AVERAGE CHILD BEHAVES -- FROM BIRTH TO AGE FIVE

Demonstrates basic areas of growth and shows how different facets are related in total development during the important, early years of childhood. It is meant to sharpen parental perception and increase parental confidence in judging what is best for the child. Five Color Filmstrips and Cassette Tape, Audible/Inaudible Signal.

FROM BIRTH TO ONE: A Time of Remarkable Growth	10 Min.
FROM ONE TO TWO: The Toddler Emerges	10 Min.
FROM TWO TO THREE: Pushing for Independence	10 Min.
FROM THREE TO FOUR: Socialization is the Task	10 Min.
FROM FOUR TO FIVE: Entering the Big World	10 Min.

LANGUAGE DEVELOPMENT

Based on recent studies of language acquisition, this film notes that children worldwide progress through the same sequence of language states at about the same rate. Various language specialists are interviewed and David Premack's work with chimps is illustrated. (McGraw-Hill). AVAILABLE ONLY FROM OCTOBER 1 THROUGH APRIL 30.
Color. 20 Min.

ROCK A BYE BABY

In the years from birth to three, the mother-child relationship is paramount in human development. The film examines some of the techniques psychologists use in their attempt to weigh and measure mothering practices around the world, with a strong emphasis on research in applicable animal behavior.
Motion picture, 27 Min.

(May also be rented from Audio Visual Library Service, University of Minnesota and New York University Film Library).

TEACHING INFANTS & TODDLERS (3/4" Cassette Videotape)

During the last ten to fifteen years researchers have discovered that babies and young children are "learners" as much as school-age and teenagers are. It may be at a different level, but the concepts or things learned at this very early age are just as important or perhaps even more than those learned at a later age.

TEACH YOUR BABY ONE TO THREE MONTHS	10 Min.
TEACH YOUR BABY FOUR TO FIVE MONTHS	10 Min.
TEACH YOUR BABY SIX TO EIGHT MONTHS	10 Min.
TEACH YOUR BABY NINE TO ELEVEN MONTHS	10 Min.
TEACH YOUR BABY TWELVE TO FOURTEEN MONTHS	20 Min.
TEACH YOUR BABY FIFTEEN TO TWENTY MONTHS	20 Min.
TEACH YOUR BABY TWENTY-ONE TO TWENTY-NINE MONTHS	20 Min.

WITH CARE AND RESPECT (Film Series)

1. ON THEIR OWN/WITH OUR HELP
   As several babies freely explore a playroom, infant specialist Magda Gerber shows when NOT to interfere with their choices and solutions. When she does offer help, she involves the infant's active participation.
   Color. 15 Min.

2. THE WAY WE SEE THEM
   Watching infants interact and engage in self-teaching, viewers learn first hand the values of careful observation. Commentary by Dr. Thomas Forrest helps us appreciate the infant's resourcefulness, tolerance of frustration and individual learning styles.
   Color. 15 Min.

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The following materials are available from Project Childsafe, Minnesota Safety Council (Free Loan).

CAR SAFETY: DON'T RISK YOUR CHILD'S LIFE

A Physicians for Automotive Safety film illustrating safe restraints for children of all ages and how to use them. Test accidents demonstrated.

12 minutes, color, 16 mm, sound.

CHILDREN AND INFANTS IN CAR CRASHES: RESTRAINED AND UNRESTRAINED

Silent crash test footage shows how fatalities and injuries occur in crashes and how restrained children are protected.

10 minutes, color, 16 mm, silent.

THE HUMAN COLLISION

Presents bio-mechanical and bio-medical aspects of crashes, function of belts and dispels myths associated with safety belt use. Documentary.

Canadian, 27 minutes, color, 16 mm, sound.

THE PERFECT GIFT

Informs audiences that traffic safety is a health issue and provides knowledge about infant passenger protection. Excellent film for expectant or new parent.

19 minutes, color, 16 mm, sound, VISUCOM.

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Films from Miscellaneous Sources.

LEARNING TO LEARN IN INFANCY

The film stresses the essential role of curiosity and exploration in learning. Describes how adults can help infants differentiate between objects and develop earliest communication skills.
Motion picture. 30 Min.

Available from: New York Uniersity Film Library (Rental)
Modern Talking Pictures (Free loan)

OBJECT PERMANENCE

Piaget's ideas about the development of object permanence in young children are demonstrated. Ranging in age from few weeks to approximately eighteen months, the children are tested in their homes.
Motion picture. 40 Min.

Available from: University of Minnesota (Rental)

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For recommended films related to nutrition, see Health Concerns Resources p. 221.

INFANT-TODDLER GROWTH AND DEVELOPMENT: BIBLIOGRAPHY

For quick reference, the infant-toddler growth and development bibliography is divided into eight topic categories. Many of the included books contain information on more than one topic, so they are listed under the category, POTPOURRI. When seeking specific information, remember to consult not only the appropriate category, but also, POTPOURRI.

Key: IR = Instructor Resource, PR = Participant Resource, G = General

1. POTPOURRI
2. EMOTIONAL GROWTH AND DEVELOPMENT
3. EVALUATION OF GROWTH AND DEVELOPMENT
4. HEALTH AND SAFETY
5. PHYSICAL DEVELOPMENT EXERCISES
6. PLAYING AND LEARNING
7. SPEECH AND LANGUAGE DEVELOPMENT
8. TOILET TRAINING

Note: NUTRITION (see Health Concerns Resources beginning p. 221).
FATHERING and FAMILY RELATIONS (See FAMILY ISSUES: BIBLIOGRAPHY)

POTPOURRI

IR Baldwin, A. L. Theories of Child Development. Wiley, 1967. A survey-in-depth of seven major theories of child development. Each theory is introduced by a statement of its philosophical and methodological background and the effect of this background on the development of the theory itself. The final part of each section is devoted to a critique of the theory. The concluding chapter attempts an integrated theory of child development.

IR Brazelton, T. Berry, M.D. Doctor and Child. Delta, 1970. Doctor Brazelton
PR discusses common problems of early childhood as they come to him in his daily practice: helping your child get along with the doctor, the normal crying period, overstimulation, discipline, hyperactivity, toilet training, etc.

IR Brazelton, T. Berry, M.D. Infants and Mothers: Individual Differences
PR in Development. Delacorte, 1974. Pbk also. A month by month developmental outline for both active and quiet babies, designed to ease the anxiety of new mothers. The book emphasizes that each child's development is unique.

IR Brazelton, T. Berry, M.D. On Becoming a Family: The Growth of Attachment
PR Delacorte Press/Seymour Lawrence, New York, NY 1981. In this book, Doctor Brazelton pays particular attention to the relationship building process that goes on bewteen baby and parents. He discusses how attachment develops in stages with ups and downs, making it necessary for the parents to make new adjustments in their own relationship as they become ever more attached to their baby, finally coming to the last chapter and purpose of it all--DETACHMENT: THE GOAL OF ATTACHMENT.

IR Brazelton, T. Berry, M.D. Toddlers and Parents: A Declaration of Independence. Delacorte, 1974. Pbk also. The book has a good section on working parents and their special problems. Other topics are sibling rivalry, discipline, negativism, single parents, and self awareness. Some examples of behaviors are analyzed by the author.

IR Chance, Paul, Ph.D. Learning Through Play. (Johnson & Johnson Baby Products Co. Pediatric Round Table Series 3) Gardner Press, Inc., New York, 1979. This is a summary of the proceedings of the Round Table on Play and Learning. The subject of play and learning is looked at from the theoretical and functional points of view as well as being covered from the vantage of application by some of the most prominent and knowledgeable authorities in this field of study. This summary consists of the following chapters: I. What Is Play? II. What Good is Play? III. What Good is Play and What Will Make it Better? and IV. What? More on Play? in which the author explains that in this booklet he has attempted to synthesize "what the experts had to offer, parents, teachers, nurses, day care workers, pediatricians and others who work with children." But for the benefit of those interested in pursuing the topic further, he lists an annotated bibliography of materials that provides other treatments of the subject.

IR Deppe, Philip R. and Judith L. Sherman. The High Risk Child: A Guide
PR for Concerned Parents. MacMillan Publishing Co., 1981. This book reflects the insights and knowledge the authors have gained from their experiences, both as being parents of children who are considered high risk, and as professionals working with high risk children. The first part of the book deals with such issues as what the chances are of giving birth to a high risk child, taking care of the child before birth through proper nutrition, avoidance of harmful substances, choosing a physician, record-keeping, and normal growth and development of children birth through eight years of age. Next, the book deals with the important issue of assessment for the child, what different professionals do, and how, in that process the parent may be the only person who puts the pieces together, who views the child as a whole. Finally, the book discusses the parent's and the child's rights and how the parents can obtain the help best suited for this child, ending with a chapter "Final Words" which is a collection of thoughts parents of high risk children wish to share with other parents.

This is an easily read, practical book and contains a listing of parent associations, a glossary and bibliography.

IR he Diagram Group. Child's Body. Paddington Press, Ltd., New York, 1977.
PR Child's Body describes and clarifies for parents and child care workers the complexities of each child's growth and development from conception through birth. It covers almost every aspect of child development and care in easy to understand language supported by informative illustrations. Specific to health care are the following topics: Parts of the Body, The Sick Child, Children in Need of Special Care, and First Aid.

IR PR Dodson, Fitzhugh. How to Father. Nash, 1974. Pbk also. This book is appropriate for mothers, too. Tells what to expect from children at different stages. Outstanding appendices on toys, books, records, encyclopedias, magazines, and books for parents.

IR Exploring Childhood. Babies Are Beginnings. Exploring Childhood, 1978. (EDC School and Society Programs, 55 Chapel St., Newton, MA 02160). A set of 24 activity cards designed to provide opportunities for students to discover that babies are actively learning all the time, and just as actively influencing the lives of those around them. Activities such as making baby food and studying a baby's growing mobility.

IR Gesell, Arnold et al. Infant and Child in the Culture of Today: The Guidance of Development in Home and Nursery School. Harper & Row, 1974. The book discusses the child from birth to five years. The most typical traits and growth trends of each age are summarized in a behavioral profile and a behavior day. The profile gives a quick thumbnail sketch of the behavior and growth patterns of a child that age.

G Hymes, Jesild. The Child Under Six. Prentice, 1963. Down-to earth, relaxed and reassuring explanation of some of the deeper meanings behind the behavior of young children.

IR PR Ilg, Frances and Louise Bates Ames. Child Behavior. Harper & Row, 1955. Pbk also. The authors provide specific advice for specific ages: Eating behavior; sleeping and dreams; elimination; tension outlets; fear; sexual development; parent-child relationships; sibling relationships; comics, television and movies; school; social behavior; ethical sense; and discipline. One of the best all-around guides on child development offering sound and practical information.

G Isaacs, Susan. The Nursery Years: The Mind of the Child From Birth to Six Years. Schocken, 1968. Pbk also. A "classic" by an English psychologist. First written in 1929 and it still shows the contrast in child-rearing philosophies. Good list of some "Don'ts for Parents."

IR PR Jackson, Jane Flannery and Joseph H. Jackson. Infant Culture, The New American Library, Inc., New York, 1978. Infant Culture provides "complete and accurate documentation of recent keystone research endeavors with infants carried out by developmental psychologists, particularly in the area of social development and communication," according to Dr. T. B. Brazelton's forward of the book. It presents recent research on infancy, explains the testing methods used and the often times, startling discoveries made. It provides for the reader a fascinating portrait of just how complex and adaptable human beings are from the moment of birth through a solid overview of research data without the burdensome use of tedious professional jargon.

IR PR Leach, Penelope. Your Baby and Child. Alfred A. Knopf, New York, 1980. This book, written by someone who draws on her experience as mother, psychologist and expert in child development, is a comprehensive, authoritative and sensitive guide for parents of children ages birth

to age five. It discusses the basics of feeding sleeping, eliminating teething, bathing and dressing. It also discusses the child's normal development and the activities that make the parent-child relationship rewarding for both. This is perhaps the most practical and reliable parenting book for parents on the market today.

IR PR McDiarmid, Norma et al. Loving and Learning: Interacting With Your Child from Birth to Three. Harcourt, 1975. Easy, readable book, with many good photographs of fathers and children. The authors show how love, physical contact, and simple interaction with a baby or toddler will foster the child's curiosity and lead to emotional stability. Emphasis is on the fun of doing things together--playing, loving, and learning together. Many activities, exercises and games to stimulate a child.

G Newton, Miles. The Family Book of Child Care. Harper & Row, 1957. The book contains a vast amount of useful information on child-rearing from conception to adolescence, stressing some frequently neglected aspects of child care.

IR Princeton Center for Infancy. The First Twelve Months of Life: Your Baby's Growth Month by Month. Grosset & Dunlap, 1974. Pbk also. Month-by-month physical, sensory, social and mental development are described. A growth chart and appealing photographs accompany each month's presentation. (Some parents become intimidated due to high expectations of "normal").

G Princeton Center for Infancy. Parent's Yellow Pages. Anchor, 1978. A parent resource written in a problem-solving format. One hundred-thirty subjects such as: babysitters, toilet learning, dental health, discipline, feeding baby, infant and toddler equipment. Each subject contains a short overview, alternative solutions, organizations that can be of help, and book reviews.

G Princeton Center for Infancy. The Parenting Advisor. Doubleday, 1977. Parents of the Princeton Center for Infancy condensed the viewpoints of learning experts from over 800 books on child-rearing practices. Easy-to-use guide to the latest theory on every aspect of parenting, behavior patterns and routines, feeding and nutrition, the healthy baby, the sick baby, sensory and social powers, physical development, language acquisition, how babies learn, play and playthings, personality formation, today's family, clothing and equipment, enrichment activities.

PR Richards, Martin. Infancy: World of the Newborn. Harper & Row, New York, 1980. The author in writing this book on babies, from birth to approximately 18 months of age, has drawn on his own experience as a parent and as a child psychologist as well as on research studies in the area of infant development. He provides parents with a picture of babies growing up in our society and how their baby is a totally unique individual and yet surprisingly like other babies. The text is very appropriately and beautifully supported by the use of black and white and colored photographs throughout.

G Saunders, Minta. The ABC's of Learning in Infancy. Infant Care Project, 1971. (University of North Carolina at Greensboro, Greensboro, NC 27412). This booklet discusses some of the basic theories of child development. Divided into three sections: A is for Activity; B is for Beginnings; C is for Curiosity. The last statement in the booklet best describes its intent: "easy first lesson in enjoying babyhood and making earliest childhood a delight for all who share in it."

IR PR Segal, Marilyn. From Birth to One Year. Nova University, 1974 (3301 College Avenue, Fort Lauderdale, FL 33314). A manual for parents that follows a typical baby through his/her first year of life using his/her body, sense and mind to communicate. Describes important learning that occurs and suggests how an adult can assist that learning through activities. Toy making directions also. Excellent photographs.

IR PR Segal, Marilyn and Don Adcock. From One to Two Years. Nova University 1976 (3301 College Avenue, Fort Lauderdale, FL 33314). The book describes toddler imagination, problem solving, discoveries and achievement, plus learning about self and others. Many valuable photographs.

PR Simont, Marc and The Boston Children's Medical Center Staff. A Child's Eye View of the World. Delacorte, 1972. A "painless guide to child-rearing." Cartoon format shows the world as a baby sees it (first encounters with other small children, a new baby, the toilet, a horse). The illustrations provide startling and often hilarious insights into a young child's feelings and fantasies.

G Smith, Helen Wheeler. Survival Handbook for Preschool Mothers. Follet, 1978. The author has interpreted and condensed technical research in child development into concise, understandable language. She explains how to survive the preschool years and how to help the infant develop into a healthy, happy, well-adjusted child.

IR PR White, Burton. The First Three Years of Life. Prentice-Hall, 1975. A detailed guide to the intellectual and emotional development of the child from birth to three years old. The book provides a comprehensive description of the characteristic physical, emotional and mental developments as well as a list of instructions concerning child-rearing practices, parental strategies, toys and equipment.

PR Wingfield, Ethel and Harry. Learning with Mother #1, 2, 3, 4 & 5. Wills and Helpworth, 1970. Set of books from the Ladybird "Under-Five" series. Each book reflects a particular age. Book 1 begins with a brief description of the baby's development from 0-7 months, then continues with monthly descriptions of typical characteristics, and activities suited to that stage. The books all contain colorful illustrations showing parents and children enjoying various activities together using appropriate materials.

EMOTIONAL GROWTH AND DEVELOPMENT

IR PR Aaronson, May and Jean Rosenfeld. Baby and Other Teachers. Day Care and Child Development Council of America, 1974. Easy-to-read parent education booklet, describing infant/toddler, parent/adult relationships and their importance to the mental health of the child. Appendix includes over 50 brief summaries of research studies about child development on which the text is based.

PR Abrahamson, David. The Emotional Care of Your Child. Simon & Schuster, 1966. Easy-to-read, practical guide for parents. Discusses the handling of children and the "why" behind their behavior.

IR PR Arnstein, Helene. The Roots of Love: Helping Your Child Learn to Love in the First Three Years of Life. Bobbs, 1975. Pbk Bantam. The author suggests that the treatment a child receives during the first three years of life, becomes the model for the child's own ideas on love. (As a child is loved, so s/he will love.) Discussion of what contributes to a loving relationship at different ages.

IR PR Briggs, Dorothy. Your Child's Self Esteem: The Key to His Life. Doubleday, 1975. Pbk also. Step-by-step guidelines for raising responsible, productive, happy children are contained in this book. Dicussion of the importance of high self-esteem for the child and how to help develop it.

G Church, Joseph. Understanding Your Child From Birth to Three. Pocket, 1975. A guide to the child's psychological development, filled with insights into an infant's growth patterns and developing needs.

IR PR Fraiberg, Selma. The Magic Years. Scribner, 1968. Pbk also. A classic investigation into personality formation during the first five years of life. The author discusses some of the typical problems that emerge with each stage of development.

IR Sroufe, Alan. Knowing and Enjoying Your Baby. Prentice-Hall, 1977. The book stresses the emotional growth of an infant and why the infant - caregiver relationship is so important. The author emphasizes enjoying a baby rather than "stimulating" his/her development. Why babies laugh and what makes them smile are discussed.

IR Thoman, Evelyn B., Ph.D. Trotter, Sherland, Editors. Social Responsiveness of Infants. (Johnson & Johnson Baby Products Co. Pediatric Round Table Series 2). This is a compilation of presentations contributed by participants at the Round Table) "Origins of the Infant's Social Responsiveness." The investigations range from very rigorous laboratory studies to naturalistic observations in the home; and from highly focused studies of such processes as perception, learning and motivation to more broadly focused research on social behavior. The three primary

areas focused on are: Section I--The Infant's Rhythms and Responses as Preparation for Partnership, Section II--Developing Designs for Viewing the Infant as a Social Being, and Section III--Onotology of the Mother Infant Relationship. This book will be of particular interest to the instructor who seeks insights into the infant's sensitivites for responses to his new environment, his devleoping capabilities during the first year of life and the infant's role as a member of the mother-infant system.

EVALUATION OF GROWTH AND DEVELOPMENT

IR Portage Project. Portage Guide to Early Education. Portage Project, Cooperative Educational Service. (Agency 12, 412 East Slifer St., Portage, WI 53901). Five hundred 5"x8" Behavior Activity Cards and checklist of behaviors to be used with normal or handicapped children from birth to six years. Instructions on how to use the material and how to identify devleopmental lags are included. Activities to develop the identified behaviors in the areas of cognition, self-help, motor, language, and socialization are included.

IR Rowan, Betty. Tuning In to Your Child: Awareness Training for Parents.
PR Humanics, 1975. A guide to help adults become more sensitive to children's growth and needs through learning good observation skills.

IR Southeastern Day Care Project. Evaluating Children's Progress: A Rating Scale for Children in Day Care. SDCP. (Southern Regional Education Board, 130 Sixth St. N.W., Atlanta, GA 30313). A booklet to help evaluate the progress of children in day care centers and family day care homes. There are rating forms which may be duplicated by anyone who wishes to use the SDCP method of evluation. Pertinent for ages birth to six.

HEALTH AND SAFETY

IR Green, Martin I. A Sigh of Relief. Bantam, 1977. The book is divided
PR into two parts: Prevention of childhood accidents and action required after an accident has occurred. A unique index system provides immediate access to guidance on how to handle just about any medical emergency.

IR Greenberg, Henry. Child Care. Rocom Press, 1973. The author discusses
PR feeding, toilet training, accident prevention, immunizations, allergy, the fussy baby, digestive problems medication and treatment. Excellent photographs of physical ailments aid identification.

PR Jones, Sandy. Good Things for Babies. Houghton Mifflin, 1976. A catalog and resource book of safety and consumer advice about products needed during the first 24 months of a baby's life.

IR Murray, Ruth and Judith Zentner. Nursing Assessment and Health Promotion Through the Life Span. Prentice Hall, Inc., Englewood Cliffs, NJ, 1975. This is a text, as the authors mention in the introduction, which introduces the reader "to the person and his family during the entire life span." This book concentrates on the normal ages and stages of development which provides the health professional with a reference point not only for assessment but also for intervention when appropriate. Chapters 2, Assessment and Health Promotion for Infant, and 3, Assessment and Health Promotion for the Toddler are especially useful for instructors of infant toddler growth and development.

PR Pantell, Robert H., M.D., James F. Freis, M.D. and Donald M. Vickery, M.D. Taking Care of Your Child--A Parent's Guide to Medical Care. Addison-Wesley Publishing House, Mass., 1977. This medical guide has been designed to give parents and caregivers an overall understanding of child-related health problems. Part I covers a variety of concerns such as prenatal care, growth and development, personality development, staying healthy, etc. Part II thoroughly covers 90 of the most common health problems, to help us determine when or when not to call the doctor, what to do in the meantime, or proper first-aid measures to apply when that is the appropriate procedure. Part III contains a place for family health records and growth charts for plotting each individual child's growth.

IR Samuels, Mike, M.D. and Nancy Samuels. The Well Baby Book. Summit Books,
PR New York, 1979. To quote the authors, "In this book we give no dogmatic solutions or advice about child-rearing; rather we try to give parents a broad, new understanding of growth and development as well as health and disease, to help them find their own solutions to the problems of raising children." Section III, Treating Illness: Medical Information and Self-Help relates most specifically to health needs. Chapters 9 through 15 cover topics such as "Emergency Medicine," "Rare Diseases," "Immunizations," etc. Good use of illustrations (drawings and photographs) for clarity and esthetic enhancements. Due to a heavy emphasis on visualization, this book may not appeal to everyone, then again, some may find it especially appealing because of it.

PR Shiller, Jack G., M.D. Childhood Illness: A Common Sense Approach. Day Books, A Division of Stein and Day Publishers, New York, 1979. The author, a practicing pediatrician, clinical professor of pediatrics and father, has written clearly and knowledgeably about the gamut of childhood illnesses that concern parents and child care workers. Childhood Illnesses covers illnesses common in children from infancy to adolescence. In Part I the chapters are arranged by symptom groups, i.e., Chapter 3: Cough, Wheeze and the Chest; Chapter 6: Rashes and the Contagious Diseases of Childhood, etc. Part II deals with separate sections on immunizations, over-the-counter drugs, special problems as well as an excellent glossary. The text is augmented with useful illustrations throughout. It will help the caring adult determine what needs to be done and when to call the doctor.

PR Shiller, Jack G., M.D. Childhood Injury: A Common Sense Approach. Stein and Day Publishers, New York, 1977. In Childhood Injury Dr. Shiller author of Childhood Illness, helps parents and child care workers find the necessary information (first aid) a specific injury calls for or how to handle severe distress until professional medical help is available. It is organized for easy reference according to symptom groups such as: Chapter 2: Cuts and Lacerations--Do They Need Stitches Chapter 6: Head Injuries; Chapter 13: Bites: Insect, Animal, Reptile, Human; etc. It also contains an appendix on each of the following topics: "Toys for Children," "Motor Vehicle Safety," and "Poisonous Plants." The text is augmented with clear and helpful illustrations.

PHYSICAL DEVELOPMENT EXERCISES

IR Koch, Jaroslav. Total Baby Development. Wyden, 1976. 330 "gentle
PR exercises and games," not to accelerate physical development, but to assure infants an ample opportunity to develop in an atmosphere of affectionate and sensitive caring.

PR Levy, Janine. The Baby Exercise Book. The First Fifteen Months. Pantheon, 1974. Pbk also. Physical development exercises demonstrated via photographs, along with written directions on positioning the infant and aim of each exercise.

PR Prudden, Suzy and Jeffrey Sussman. Suzy Prudden's Creative Fitness for Baby and Child. Day Care and Child Development Council of America, 1972. Excellent guide to help parents and caregivers enhance children's physical and emotional well-being. Part I deals with the rationale of creative fitness. Part II presents exercises with photographs. Exercises for ages 3 months to 4 years.

PLAYING AND LEARNING

IR PR Arnold, Arnold. Teaching Your Child to Learn: From Birth to School Age. Prentice-Hall, 1971. The author presents a clear, step-by-step program for teaching a child to listen, recognize, reason, draw and enjoy music. He gives compelling reasons why television, coloring books and other mechanical aids cannot (and should not)replace committed teachers and concerned parents.

PR Aston, Athina. How to Play with Your Baby. Fountain, 1972. Pbk also. The author explains how a baby develops from week to week through play. Helpful month-by-month play chart outlines activities to share with baby.

Beadle, Muriel. A Child's Mind: How Children Learn During the Critical Years from Birth to Age 5. Doubleday, 1971. A review of studies of the last 25 years that seem to support the theory that learning occurs much earlier in life and is less susceptible to later modifications than generally suspected. The author feels that success in life depends on preschool experiences that determine future academic progress and personality traits.

G Bell, T. H. and Arden Thorum. Your Child's Intellect: A Guide to Home-Based Preschool Education. Olympus, 1972. Pbk also. The author believes that education should begin at birth. Furthermore, that it should take place in the home, not in an institutionalized setting. Theoretical basis for program, plus step-by-step practical applications utilizing ordinary household items and readily available materials are included. Year-by-year program of home-based teaching for the child from brith through five years.

IR PR Braga, Joseph and Laurie. Children and Adults: Activities for Growing Together. Prentice, 1976. This book describes developmental ages/ stages and activities that complement them. This book is designed to bridge the gap between research and theory in the behavioral sciences and practical application by readers.

PR Burt, Kent Gartland, and Karen Kalkstein. Smart Toys for Babies from Birth to Two. Harper & Row, New York, 1981. This book contains 77 easy-to-make toys to stimulate the baby's mind. Many of the ideas and toy designs are based on the research findings of the Harvard Preschool Project which was directed by Burton White, Ph.D. It supplies specific suggestions for parents wishing to educate their infant and toddler with toys they can easily make at home. It includes information on the successive phases of development, stressing the changing interests and abilities for each phase; patterns, step-by-step instructions and a complete list of materials, required for each toy; and the reason for the toy and recommendations on just when, where and how to present it. Guaranteed to make parenting more interesting and more fun.

PR Gordon, Ira J. Baby Learning Through Play: A Parent's Guide for the First Two Years. St. Martins Press, 1970. Games to bring pleasure, security, self-esteem and intellectual growth to the child three months to two years are contained in this book.

PR Gordon, Ira J. Baby to Parent--Parent to Baby: A Guide to Loving and Learning in a Child's First Year. St. Martins Press, 1978. A practical guide to developing parent-child interaction in the first twelve months: developing responsiveness through touch, body and eye contacts; what to expect of an infant; child-rearing as a partnership; observing and adapting to the child's own rhythm; solutions for two working parents or single parents.

PR Gregg, Elizabeth and the Boston Child's Medical Staff. What to Do When There's Nothing to Do: A Mother's Handbook. Delacorte, 1968. Pbk Dell. A guide to making toys from everyday things around the house. A mothering guide, too, particularly for difficult days. Appendix lists books and records for children.

PR Hagstrom, Julie and Joan Morrill. Games Babies Play. A & W Visual Library, New York, 1979. A nicely illustrated book, presenting a series of structured games for babies from birth to age one. Although it is promoted as containing games that range from quiet, relaxing bedtime games to highly stimulating, fast-moving suspense games, they are mostly of the in-between variety of common sense activities that help parents, grandparents, etc. gain a healthy perspective of the usefulness of old standby's, such as "Pat-a-Cake" encouraging concentration and coordination to "Kitchen Patrol" which encourages skill development in the areas of discriminating between shapes and sizes, hand coordination and verbal development by setting up an imitative play situation for the baby while cooking. A book of useful hints and ideas that should be used judiciously, not as gospel.

(Also see sequel: Hagstrom, Julie. More Games Babies Play, A & W Visual Library, New York, 1981.)

PR Kaban, Barbara. Choosing Toys for Children from Birth to Five. Schocken Books, Inc., 1979.

PR Lally, Ronald and Ira J. Gordon. Learning Games for Infants and Toddlers. New Readers Press, 1977. The book contains insights into ways that adults can help children reach their full capacity. Sixty-four games designed to intellectually stimulate and develop children from two months to two years. Each game is simply explained, with key actions clearly illustrated. Easy reading.

IR Liepmann, Lise. Your Child's Sensory World. Penguin, 1974. A practical book about an area of learning that is often overlooked--understanding a child's sensory patterns. Since the child's sensory world influences the child's whole way of life, the author reviews how to discover a child's sensory powers. Fun games and exercises to increase awareness.

IR Linderman, C. Emma. Teachables from Trashables. Toys 'n Things, 1977.
PR (906 N. Dale St., St. Paul, MN 55103). A practical, step-by-step guide to making safe and fun learning toys from recycled household "junk." Safety tips for making "kid-proofed" toys. Toys for infants through school-age children.

PR Marzollo, Jean. Supertot: Creative Learning Activities for Children from One to Three and Sympathetic Advice for Their Parents. Harper & Row, 1977. The author's purpose in this book is to suggest learning activities that help children develop some aspect of their potential. It contains sections covering toys to make; games to play; and art, music and dance activities. Hints for starting a playgroup are included.

IR Munger, Evelyn Moats and Susan Jane Bowdon. Beyond Peek-A-Boo and Pat-a-Cake.
PR Follett Publishing Co., Chicago, 1980. To quote Dr. William Fullard in his forward to this book it "combines current information from pediatrics and psychology about child development with a number of techniques for interacting with or stimulating an infant . . . they serve as very practical guides to help parents become sensitive observers and to accept a complementary rather than a passive ('I don't really know what to do') role during the early months." This is truly one of the most practical and comprehensive books written to help parents and their baby learn about the realities of living with and developing a mutual enjoyment of each other during the baby's first year. The authors provide specific suggestions about "how to play, what to say, short cuts for everyday routines, tips on handling babies in general." Pros and novices, parents and instructors will find it a most useful resource.

G Painter, Genevieve. Teach Your Child. Simon & Schuster, 1971. The author believes that parents are the most effective teachers of their own babies. She presents a completely tested program of simple daily activities that parents and children will find enjoyable and rewarding. The activities are designed for every stage of development from infancy to four years.

IR Stein, Sara Bonnett. New Parents' Guide to Early Learning. New American
PR Library, 1976. The author offers advice on how to enrich the preschool years. She traces a child's pattern of development from birth through preschool, shows what skills appear at what time, describes a parent's use of language, and choices of toys. She suggests ways of guiding rather than pushing a child to realize maximum learning potential.

IR Sutton-Smith, Brian and Shirley. How to Play with Your Children: And When
PR Not To. Hawthorn, 1974. The authors give parents play ideas for children from birth to 13 years. Includes a brief assessment of what parents can expect in their children's behavior year by year.

PR Upchurch, Beverly. Easy-To-Do Toys and Activites for Infants and Toddlers. Infant Care Project (University of North Carolina at Greensboro, Greensboro, NC 27412). Homemade toys, activities, records, action songs and rhymes, mobiles and wall decorations in a handy manual. Includes a listing of materials, how to organize them, and where to get them.

SPEECH AND LANGUAGE DEVELOPMENT

IR Pizzo, Peg Daly and Judy Manning. How Babies Learn to Talk. Day Care and
PR Child Development Council of America. A deceptively simple presentation on language development in babies and young children. Included are very useful research notes in the form of an annotated bibliography used by the authors in writing this book.

IR Pushaw, David R. Teach Your Child to Talk: A Parent Guide. International
PR Scholastic Book Service, 1977. Explains typical speech and language development from birth to five years. Includes suggested activities to enhance communication development. Extensive appendix.

TOILET TRAINING

IR Mack, Alison. Toilet Learning: The Picture Book Technique for Children
PR and Parents. Little, Brown and Co., 1978. The author believes that toilet learning, which is something a child does himself-herself, is unlike toilet training, which is something grown-ups do to a child. Part I is written for the parent. Part II is a picture story for the child. The picture story refers to elimination as "wee-wee" and "doo-doo."

IR Selzer, Joel Graham. No More Diapers. Delacorte, 1977. A well illustrated
PR picture book about the toilet learning of a little girl and a little boy. The first section of the book contains practical and sound advice for parents.

HEALTH CONCERNS

RESOURCES

GENERAL SIGNS AND SYMPTOMS OF ILLNESS

In spite of the good everyday care you give your child, he/she may still become ill. Whatever the illness, he/she will need your special attention and skill. Besides keeping regular "check-up" appointments to assure his/her continued health, you will want to become aware of and deal with the first signs of illness, for it's better to err on the side of caution than to ignore a symptom that could lead to something serious. The following is a list of things to keep in mind when dealing with a sick child.

A. Before You Call the Doctor

1. OBSERVE THE CHILD

2. Check temperature

3. Note signs and symptoms - write them down and tell them to your doctor as well as any other questions you have.

4. Be prepared to write down any instructions your doctor may give you and don't be afraid to ask him to repeat instructions or ask questions about them. Repeat all instructions back to the doctor to be sure you have them correct, especially medications and special diets.

B. Signs and Symptoms Check List

1. Common Cold

   a. Temperature? When . . . how long?

   b. Any activity change? Less energetic?

   c. Not hungry? Even for favorite foods?

   d. Vomiting? When? How much? What does it look like? Smell like? Is it bloody?

   e. Headache? Holds head?

   f. Red eyes? Puss in eyes? Watery eyes?

   g. Earache? Pain? Pulling on ears? Discharge from ears? How much and what does it look like? Bleeding?

   h. Coughing? Severe? When and how much? Vomits when coughs? How does it sound?

   i. Fast, difficult looking and sounding breathing?

   j. Does s/he look and act sick? Limp? Tired? Lethargic? Irritable and cranky?

k. Runny nose? Crusting around nose? What does discharge look like? How much?

l. Sore, red throat? How long? When?

m. Rash? What does it look like? Where is it? Where did it start? Is it "weepy"? Itchy?, etc.

2. Diarrhea

a. Check for fever. When? How long? How much?

b. Bowel movements. What do they look like? How many? How often? Any blood or puss-like materials? Any unusual color changes?

c. Vomiting? How much?, etc.

d. Runny nose?, etc.

e. Eyes sunken?

f. Cough?, etc.

g. Is s/he passing her/his urine normally? What color is it? How often? How much? Bleeding?

h. Does s/he look sick?, etc.

3. Vomiting

a. How much? How often? When? For how long?

b. What has s/he eaten or drunk? How much?, etc.

c. What does it look like? Smell? Bleeding?, etc.

d. Temperature?, etc.

e. Sweating? How much? When? How long?

f. Unusual smell on breath or body? When did you notice?

g. St[illegible]h ache? How long? When and where?

h. Diarrhea?, etc.

i. Passing urine normally?, etc.

j. Does s/he look sick?

4. Eye and Vision Problems

a. Redness?

b. Tearing?

c. Pain?

d. Irritation?

e. Constantly rubbing eyes?

f. Blinking more than normally?

g. Repeated frowning or squinting?

h. Holding objects extremely close or moving up to an object to look at it.

5. Ears and Hearing Problems

   a. Pain in ear? Pulling on ear? Discharge from ear? When? How much?

   b. Hearing loss? How long? Asks to have things repeated? Turns up TV?

   c. Buzzing or ringing in ear?

   d. Dizziness or unsteadiness? When? How long?

   e. Recurrent fever?

6. Allergies

   a. Foods. Any new foods? When did it start? How does it look?

   b. Skin contact or touch. Plants? Soaps? Clothes? Metals?, etc. Rash?

   c. Respiratory or breathing reactions. Pollens? Dust, feathers, pets, molds?, etc. Runny nose? Red teary eyes? Sneezing? Coughing, wheezing, difficult breathing?

   d. Medications. Rash? Breathing problems? Is there a history of allergies in the child's family?

7. Falls

   a. Bump or bruise? Where? How big? Has it changed size or color? Painful?

   b. Bleeding? Where? How much? How fast? Bright or dark red? Consciousness? Can't awaken?

   c. Vomiting?

   d. Pain, headache?

   e. Arm, leg, finger, etc. Does it look unusual? Swollen? "Bent funny"? Can't move or use?

FEVER CONTROL OF CHILDREN

An elevated temperature (over one degree above normal) can be controlled with oral aspiran or acetaminophen (Liquiprin, Tempra, or Tylenol). If vomiting occurs, rectal suppositories of the same medications are available at your pharmacy.

Before taking any temperature, remember to shake the mercury down below 96°F.

Oral temperature - hold under the tongue for at least three minutes. Do not use for children under 5 years of age or for children with a "cold" who cannot breathe through their nose. Normal is about 98.6°F.

Axillary temperature - put the thermometer in the child's armpit and hold tightly for at least five minutes. This is the least accurate method for taking a temperature. Normal is about 97.6°F.

Rectal temperature - use a rectal thermometer that has a rounded adult. Lubricate the bulb and insert gently into the rectum about one inch. Keep in place at least one minute. Normal is about 99.6°F.

Baby aspirin contains 1½ to 1¼ grains per tablet, depending on the brand. A good safe rule of thumb is to give 1 (one) grain of aspirin for each year of age up to 10 years, every four hours. Crush and give in a small amount of water for infants.

Acetaminophen (Liquiprin, Tempra, Tylenol) can also be purchased without a prescription. Dose is 1 grain or 60 mgms. for each year of life every 4 hours.

AGE	Tylenol/Tempra Drops	Tylenol/Tempra Syrup	Liquiprin Drops	1¼ Grain Baby Aspirin
0-6 months	0.3 cc or ml	¼ tsp	0.6 cc or ml	½ tablet
6-12 months	0.6 cc or ml	½ tsp	1.25 cc	1 tablet
1-2 years	0.6 cc or ml	½ tsp	1.25 cc	1 tablet
2-3 years	1.2 cc or ml	1 tsp	2.5 cc or ml	2 tablets
3-4 years	2.4 cc or ml	1½ tsp	3.75 cc or ml	2½ tablets
4-5 years	3.6 cc or ml	2 tsp	5.00 cc or ml	3½ tablets

The above dosages may be repeated at 4 hour intervals.

Tepid (lukewarm) water sponge baths should be used in addition to the medicines for temperatures over 104°F. The child should be placed in 2 or 3 inches of tepid water, making certain to rub the arms, legs, and trunk to increase the circulation. This should be continued until the temperature is below 103°F. One or two 15 minute sessions will usually accomplish this. For children over 5 years, sponge baths are not necessary or effective. For the young child, sponging will always bring the temperature down.

Fluid intake is important when fever is present. Fluid requirements rise about 7% with each degree above normal temperature, so that a child with a temperature of 104°F needs 30-35% more fluid than normally. If your child will not drink a good amount at one sitting, small amounts at frequent intervals will often provide a good total intake.

Final note: Do not over dress the child with a fever. This only increases the fever.

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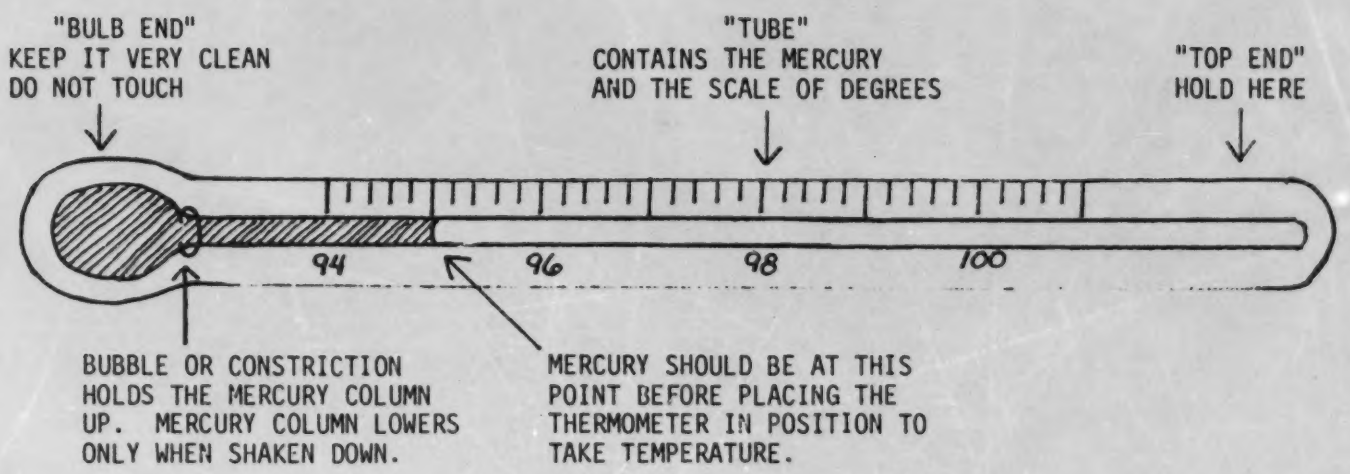
HOW TO USE AND READ A THERMOMETER*



Normals

98.6°F (37°C) ORAL (mouth) - Hold in place at least 3 minutes; moisten with water before using.

97.6°F (36.4°C) AXILLARY (arm pit) - Hold in place at least 5 minutes; thermometer remains dry.

99.6°F (37.6°C) RECTAL (rectum) - Hold in place at least 1 minute; lubricate with thin coat of vaseline before using.

ALWAYS CLEANSE THE THERMOMETER BEFORE PLACING IN CASE. USE SOAP, COOL WATER AND FRICTION AS YOUR CLEANSING AGENT.

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*Adapted from American Red Cross materials

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HEALTH CONCERNS--HEALTH HINTS

Things to Keep in Mind When Working with Children *

As caring adults, none of us "intentionally" jeopardizes a child's well-being by placing him or her in an unsafe situation. There are, however, many times that we do so unintentionally. Sometimes this happens because we have never "experienced" and "felt" the fear and panic of seeing a choking child struggle for breath, or had to pace the floor in an emergency ward awaiting the verdict while doctors are doing their best to save the baby, who had only a half-hour earlier, been happily exploring a lamp cord with her brand new teeth. And, at other times we place children's lives on the line because we fail to take into account what is "normal" for most children at certain developmental stages and/or, the fact that in spite of certain averages, each child is also unique. Thus, we assume that all two-month-olds are safe left on a sofa for a moment or two until we leave little Joe there who promptly wriggles and falls to the floor and suffers a severe concussion.

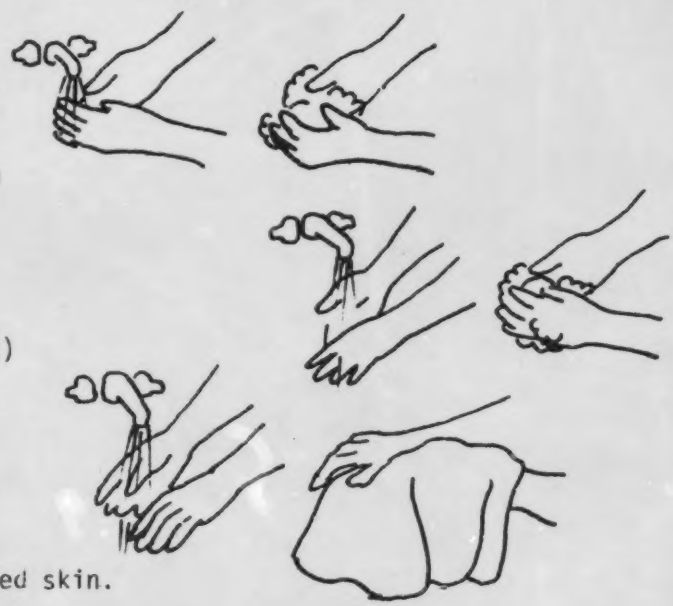
As you read the following section keep some of the old adages such as "prevention is the best cure," "a stitch in time saves nine" etc. in mind, and you will be richly rewarded by fewer accidents and health problems, and your child will enjoy the freedom to grow to his fullest potential.

Some Important Sanitary Procedures

Handwashing: Always wash hands thoroughly *before* and *after* diapering the baby.

To correctly wash hands:

1. Wet hands with running water (any temperature).
2. Soap hands well, rubbing each hand well.
3. Rinse with running water.
4. Soap again (rinse soap before replacing in soap dish) again apply friction. This time the soap should lather well.
5. Rinse under running water until all soap is removed.
6. Dry thoroughly to avoid chapped skin.



Follow this procedure after wiping noses, before preparing food, feeding children and after diapering. Help the children learn the same routines by teaching them the proper hand-washing techniques and when to use them, as part of your daily activities with them--beginning at infancy.

--Dispose of contaminated tissue immediately.

--Don't make a child "blow" into the tissue but simply wipe away the mucus. Blowing often forces fluids into the ear canal promoting infections in the middle ear.

Establishing Good Personal Hygiene Habits

--Dispose of diapers in a covered container immediately.

--When toddlers are learning to wipe themselves, teach them to wipe from front to back, making sure that all stool is cleaned away. This is especially important in little girls who are very susceptible to vaginitis as well as bladder and kidney infections. Boys may also become infected if their undershorts become heavily smeared with stool.

--Of course, always practice proper hand-washing techniques.

Outlets and Electrical Cords

--Cover all outlets, accessible to an infant or toddler, with inconspicuous and difficult-to-remove safety covers.

--Never leave appliance or lampcords within the reach of a young child.

--Place heavy furniture in front of outlets that have to be used for lamps.

--Teach older children proper handling of electrical appliances and cords.

Water Safety

--A child can drown in less than one inch of water so do not ever leave an infant or toddler unattended in any type of pool or tub.

--Be sure older children are supervised when swimming.

--Be sure all pools or ponds accessible to children are fenced and locked when not under supervision by a responsible adult.

--Be sure diaper pails are locked or not accessible to young children.

Hot Water Dangers

Hot water in the home or child care facility can cause severe burns. Most adults can react quickly enough to avoid serious burns from hot water; a young child, however, may not. Since hot water heaters are often set at 140° F, a temperature which can scald a child in six seconds, it is necessary to set the water heater at about 120° or less.

Fires and Burns

--Never leave a charcoal fire unattended with young children around.

--Keep cigarette lighters and matches put away.

--Plan and practice exit routines to be followed in case of fire. How do you get a sleeping infant and a headstrong frightened toddler out in the middle of winter all by yourself? Where will you go? Who can help?

--Keep all cooking utensil handles turned in when cooking.

Checking for Toxins

--Learn which plants are poisonous. Remember young children learn through their mouths so keep "suspect" houseplants out of their reach and keep a close watch when they are outside.

--Whether you buy or make your own art materials, check to see that they are non-toxic. Remember that excessive amounts of salt, as in some homemade playdoughs, can be fatal to a tiny tot.

--Check any old toys and equipment you may bet second-hand for lead-base paint. Also, have paint chips tested by your city or county health department if you live in an older house. Lead poisoning is a preventable form of epilepsy, do your best to prevent it.

--Store all household cleaners, medications, vitamins and alcoholic beverages behind locked doors. One toddler, in recent memory, made steps out of counter drawers, climbing them to the counter, navigated across a stove top, a sink and scaled a refrigerator in order to get more of those delicious animal shaped vitamins stored "out of reach" in the cabinet above the refrigerator.

--Never administer medications in a semi-dark or dark room. You may accidently give the child the wrong medicine.

--Give only medications which have been prescribed by the doctor for your child. That includes baby aspirin and syrup of ipecac.

--Have the number of the poison control center listed by your telephone. Call them for advice on what to do in case of accidental poisonings.

Materials and Equipment Considerations

The U.S. Consumer Safety Commission offers the following guidelines for us to keep in mind regarding the selection and use of furniture designed for children.

How do you protect children from falls from high places? A good way to prevent many falls is to pay close attention to small children anywhere they might fall. Watch infants very carefully when they are on a bed, sofa, counter top, dressing table or similar piece of furniture. Use guard fences at the top and bottom of stairways to block them off to infants too young to use them safely.

Cribs. Federal safety regulations for full-size cribs became effective February 1, 1974; and for non-full-size cribs, August 10, 1976. These regulations require that spaces between slats be no more than 2-3/8 inches to prevent infants from slipping between slats. They also set a minimum distance between the top of the mattress and the top of the side rail to help prevent children from climbing over the rail.

If you own a crib that was manufactured before the regulations went into effect, be sure to use bumper pads, securely tied in place, to prevent falls between the slats. These are particularly dangerous because an infant's body will usually pass between the slats, but the head will not and the child could be strangled. Remove bumper pads once the child can stand up to prevent them from being used to climb out.

As soon as a child can stand up, set the mattress at its lowest position and lock the side rail at its highest position. Do not put boxes or large toys in the crib that could be used for climbing.

Remove children from cribs once the side rail height is less than three-quarters of their height.

Infant Carriers. (Plastic seat-type) If you buy an infant carrier, be sure that it is stable; usually, the wider its base, the more difficult it will be for a child to upset it.

Keep an infant carrier away from the edge of any high surface. Never leave a baby unattended in an infant carrier.

Always use any belts or other restraining devices provided.

Be sure the carrier has a non-skid surface on the bottom. If it doesn't, attach rough-surfaced adhesive strips.

Dressing Tables. Always strap the baby in place on a dressing table. Remember, though, that even straps do not always prevent falls. They are no substitute for close supervision.

A table with guard rails offers some additional protection against infant falls. So would a table with a recessed rather than flat top.

High Chairs. Select a high chair that is stable--one that cannot be pushed or tipped over easily and that will not fold up while the child is in the chair. Check the tray to be certain that it is properly locked in place. Be sure that the child is strapped in properly and that the straps are secure.

Teach children not to stand in high chairs, and caution older children not to climb on them.

Baby Walkers. Select a stable baby walker, one with a wheel base wider and longer than the frame. Baby walkers can tip over when moving from one surface to another--from rug to floor, over a door threshold, from a sidewalk to a lawn. The ideal play area for a baby walker is a flat, smooth surface. Always use guard fences at the top of a flight of stairs to prevent falls.

Playpens. Do not leave large toys or boxes inside the playpen that could be used for climbing. Likewise, avoid decorative items which tie or strap across the top of a playpen since children can also use these for climbing.

The playpen should not be used once a child is able to climb over the side.

Toy Boxes and Toy Chests. If you plan to purchase a toy chest or toy box or if you already own such a product, the Consumer Product Safety Commission offers the following advice:

Selection:

--If you are buying a chest or box with a hinged lid, be sure that the lid is light-weight and has a flat inner surface and that it has a device that will hold it open in a raised position so that it will not slam shut of its own weight. There is some evidence that a lid with protrusions or recessed areas on the inner side may make it more difficult for a child to get free should the lid close on the head accidently. Make sure that the device to hold the lid open is not able to pinch.

--Check for rough or sharp edges on all metal components and for splinters and other rough areas on wooden boxes.

--Rounded and padded edges and corners may prevent some injuries and reduce the severity of others.

--The toy box or chest should be well-ventilated. This means ventilation holes in the lid and at least one side, near the top; ventilation holes near the top on two opposite sides; or a product with a lid that cannot close completely.

--It should not be possible to lock the lid of the toy box or chest.

Toy Box Use:

Some injuries caused by falls against the box are quite serious; at least one was fatal. To reduce the chance of such an injury:

--Don't put the box in a heavily travelled area.

--Caution your children against running or roughhousing near it.

--While it's impossible to keep the area around a toy chest free of clutter while children are playing, take advantage of the time they're asleep or outside to clear it up so that toys don't accumulate.

--Don't contribute to the hazard by making the footing underneath insecure, such as by using throw rugs on a waxed floor.

--If you own a box with a lid that may be hazardous--one that is heavy, has a recessed inner surface, or will not hold in an open position, or a box with poor ventilation, the hazard can be eliminated by removing the lid.

Better, yet, use low sturdy shelves for storing the baby's toys and forget the toy box entirely. For large balls, etc., a plastic laundry basket does well.

Strollers. Check the stroller for safety by asking yourself the following questions:

1. Does it have a scissor-like slicing action when snapped into an open position? Could the x-joints on the rear conceivably pinch or crush a baby's hand or finger in the process of closing it?

2. Do the brakes have positive locking action with tabs that fit firmly into the spokes of the wheel?

3. Will the stroller remain stable even if a baby stood up in the seat and leaned backwards? Test the "tippability" of the stroller by pressing on the back handles.
4. Does it have both a waist and crotch restraining belt which can be adjusted snugly around a baby of any size?
5. Does it have a firm, supportive back, rather than the sling type backs which often cause the baby to slump forward?
6. Does it have an adjustable footrest which can be placed so the baby can actually contact it?
7. Does it have flexible tires rather than rigid plastic "balloon" tires to protect against excess jarring?
8. Does it have a well-balanced frame and wheels that turn all at once? Can you steer it with one hand?

Car Seats. According to the editors of Consumer Guide the following points are important to keep in mind when purchasing and using child restraint systems.

1. Car seats which have a tether strap coming out of the upper back portion provide superior protection by anchoring the car seat to the car and preventing the seat from striking the side or the front of the car's interior.
2. Seats which combine molded seat shells with tubular steel under framing are safer and more durable, on the whole, than seats which consist of separate base, back, and headrest mounted on aluminum or other metal tubing.
3. It is extremely dangerous for any child to ride in large rear area of a station wagon! Never allow this practice.
4. Never use a child's car seat on a bucket seat or on a seat which collapses forward, such as those in two door automobiles. Also, do not try to anchor the car seat by using seat belts that are on a continuous loop. In all three cases, the child should be placed in the rear center of the passenger compartment.

Other recommended features listed were:

For Infant Car Seat-(for infants up to about 20 lbs.)

--Rearward facing position

--No sharp, jagged surfaces

--High back for head protection

--Sturdy adjustable straps

For Child Car Seat-(for children generally between 20 and 40 lbs.)

--High back for head protection

--Carrier tethered to back seat of car

--Elevated seat allows viewing out windows

--One piece molded plastic shell

--Sturdy adjustable straps

Playground and Backyard Equipment Guidelines

--The equipment should match the child (or children's) age, size and physical abilities.

--Be sure equipment is free of sharp edges, rough surfaces and open-ended nooks.

--For unassembled equipment be sure to set up the equipment correctly and safely, according to instructions (be sure such instructions are included before buying).

--Locate large muscle equipment, such as swings and climbers, at least six feet away from fences, walls and other obstructions.

--Anchor legs of equipment in concrete, or other anchoring devices, for stability. These should be placed below ground level to avoid injuries caused by tripping on them or falling against them.

--Install equipment over a non-hard surface such as grass or sand. Hard surfaces such as concrete, blacktop of cinders may result in severe injuries in case of falls.

--Check periodically to see that all nuts, bolts and clamps are tight and there are no protruding nails or screws, splintering, or splitting boards.

--Climbing apparatus should be dry before children use them.

--Teach children how to use each piece of play equipment properly, encourage safe play habits and always supervise them.

Tricycle and Bicycle Safety Considerations. The U.S. Consumer Product Safety Commission offers the following suggestions for the purchase and safe use of tricycles and bicycles:

1. Selecting the Tricycle

   --Match the size of your child to the size of the tricycle. If a child is too large for the tricycle, it will be unstable. If the child is too small, it may be difficult to control the tricycle properly.

   --Low-slung tricycles with seats close to the ground offer more stability.

   --For extra stability, look for wheels that are widely spaced.

   --Avoid tricycles with sharp edges, particularly on or along fenders.

   --Look for pedals and handgrips with rough surfaces to prevent the child's hands and feet from slipping.

2. Using the Tricycle

   --Teach children safe riding habits, then check on them frequently:

   * Caution your child against riding double. Carrying a passenger on a tricycle greatly increases its instability.

   * Try to teach your child that riding down hills is dangerous. A tricycle can pick up so much speed that it becomes almost impossible to stop without brakes.

* Teach your child to avoid sharp turns, to make all turns at low speed, and not to ride down steps or over curbs.
* Advise your child to keep hands and feet away from moving spokes.

ACCIDENT PREVENTION AND CHILD SAFETY

Children are especially accident prone at certain ages - this is normal. Each age has its own built-in peril potential for you to watch for in order to protect your child.

THE INFANT. Infants, completely helpless, are perhaps the least likely to get into danger, but at the same time are unable to get out of or protect themselves from a hazardous situation. Protection is the key word. Protection is needed from falling (is the crib side secure?), and from objects (is the mobile toy above the crib firmly fastened?). Protection too may be needed from "big" people. An older child may want to help care for a younger child, but will need your help and supervision.

And then babies do grow quickly! You have to be aware of their changing abilities, not just with pride, but with an eye to their peril possibilities. "Isn't it wonderful that the baby can turn over by himself/herself?" Marvelous! But even before you ever observe him/her turn over, you have to remember never to leave him/her alone on a bed or couch or bath table. It is astonishing how fast even young infants can squirm and pivot to the edge and fall. A playpen or a blanket on the floor makes a safer playground. It is also wonderful when the baby begins to feed himself/herself - but that hand to mouth coordination means anything can get in the mouth, including safety pins, coins and Legos, and present a potential choking hazard.

THE TODDLER. The toddler is in the "age of accidents" - the age where you learn just how many things around your house are breakable and dangerous unless you have anticipated it with a "hunt for hazards". Toddlers are continually into, onto, above and under everything. They move fast and perpetually and have little appreciation of danger. Like infants, they must be protected. But the beginning of safety can be taught. They can learn the meaning of "hot", "no-no", "sharp", "not to eat". Now is the time to also train children to report their accidents at once. What was only a broken glass could become a cut finger.

COMMON ACCIDENTS - WHAT TO LOOK FOR

At times, with children around, it seems as if everything in sight means potential danger. With every child most accidents occur within a specific roll call of categories:

FALLS. All children fall and they certainly can not be protected from every bump and bruise. But here are some areas of the home that can be made much safer against falls:

Stairs, of course, are a place of accidents. Are they well lit? Does every stairway have an adequate handrail? Is there a gate at the top and bottom? Do you make it a rule that nothing is left on the stairs? Do you insist that roller skates be stored safely, and never on stairs? Are there any loose rugs on or near the stairs? And the bathroom! Ideally, tub and shower should have nonslip mats and firm handholds. The strap on the infant's bathinette should always be used in order to keep the baby safe on to never leave the infant alone, even for a second.

You can not keep children from all falls, but you can avoid tempting them into places where they almost have to fall. Look for and get rid of attractive hazards such as a household ladder left standing against the garage, open wells, or manholes.

SUFFOCATION. Most suffocation is due to small objects or pieces of food which lodge in the windpipe or further down in the bronchial tree. Small objects - coins, safety pins, buttons, beads, thumb tacks - should be properly stored out of children's reach. Some foods such as peanuts, potato chips and apple peelings should not be fed to toddlers or young preschoolers since these foods, like the above objects, present a choking hazard. To prevent choking, all materials should be either saliva-soluble, or more than 1½ inches in diameter for children under three years old. Peanuts should be off limits until children are at least four-years-old and popcorn not provided until three-years-old. Infants should never be fed by propping a bottle. This is because they often spit up and can inhale or choke on the milk. Small objects not only present a choking hazard, but if they become lodged in the lungs or stomach, they often can cause disease or infections as well as requiring surgery to remove. In addition, small objects are often retrieved from less vital but equally accessible parts of the body including the ears, nostrils and genital urinary passages.

Although normal infants or children will not smother in their bed clothes, thin plastic materials or cleaning bags should never be used as waterproof undersheets. Crib harnesses also should never be used.

Another cause of suffocation is due to children becoming locked in airtight objects. This includes freezers, refrigerators, clothes dryers and automobiles. Never leave children locked in the car even for a few minutes. On a warm day the temperature in a closed car (even with a window cracked) can rise as much as 10^{0}-20^{0} in five minutes.

CUTS. Sharp household items should be stored or disposed of safely and permanently. For example, broken glass or used razor blades should not simply be tossed in a wastebasket that the children may get into. Power tools or kitchen appliances should be disconnected and stored so they cannot accidently be turned on or pulled down by the cord.

Toys too may have sharp edges especially when they come apart or are broken by young hands. Buy well made, sturdy, unbreakable toys and discard shoddy ones before a child gets hurt by them. Keep an eye out for "new" edges on broken toys.

WHEN AND WHERE DO ACCIDENTS HAPPEN - HUNTING FOR HAZARDS

WHEN TO WATCH. Knowing when accidents occur can help you avoid them. It would be wonderful if the conditions under which most accidents occur could be avoided, but many of them cannot be, even in the most smoothly run household. Awareness of when to watch gives you an edge on prevention. Question the safety factor of the following situations.

ARE YOU OR ANOTHER FAMILY MEMBER ILL OR UNDER UNUSUAL STRESS?

The routine changes. Your regular safety practices and precautions are upset along with everything else. People are rushed and worried and have too little time for the children. Someone forgets to put the ironing board away. Medicine is left on a dressing table or the kitchen counter. An accident.

IS THE CHILD TIRED OR HUNGRY?

Dinner is late. The child is grumpy and underfoot. In your rush to prepare something to eat, you forget to turn the pot handles toward the back of the stove. An accident.

ARE DANGERS TOO EASY, TOO PRETTY TO RESIST?

The child sees you light matches from the shiny red box on the coffee table. An accident.

ARE YOU UP-TO-DATE WITH THE CHILD'S INCREASING ABILITIES?

Yesterday, the infant could not roll over, today he/she can. An accident.

GOING ON AN OUTING?

New places for the child to explore, places that you have not had a chance to check for hazards. Precautions and rules are forgotten in the excitement. An accident.

ARE YOU AT YOUR BUSIEST?

Everything to do at once. In-laws coming to dinner. Roast in the oven. The living room still a mess. The baby won't nap and the toddler....., where is he/she? An accident.

These incidents are just for this handout, but the situations and possibilities for accidents are too real. So are the precautions you can take to insure against accidents.

Safety may seem inconvenient with all the "keep out of reach", "lock up", and "procedures for disposal", but accidents are far worse than just inconvenient.

FIREARMS. There should be no exceptions to rules that apply to firearms. They should be stored, unloaded, and under lock and key. Keep ammunition locked up, but in a different place from guns.

GETTING LOST. On shopping trips children occasionally manage to get out of sight no matter how hard you may try to hold onto them. An identification card slipped into a pocket or pinned to a dress can save hours of anguish. This is a particularly appropriate precaution when planning to attend large gatherings.

WHERE TO WATCH. Every room in the house has its own built-in child accident traps. There are just so many top shelves and cabinets with locks. There is no way to fence off all your furniture and put everything breakable out of reach. Even if you could, chances are good that your child will find something to trip over or fall into. Nevertheless, you should try to remove as many hazards as possible. Take a walk through your home and check off each of the following hazards as they are eliminated.

KITCHEN	
No flammables near the stove.	
Electrical appliances, lamps and fixtures in good repair and away from water.	
Knives, sharp tools and possible poisons out of reach.	
Utensil handles turned toward the back of the stove.	
Unbreakable plastic drinking glasses for children.	
High chair and playpen well away from work counters. Are they well-built, sturdy, unpainted, or painted with lead free paint?	
Towels and curtains away from stove; clothes and hair not too "flowing".	
Adequate ventilation when gas appliances or cleaning fluids are in use.	
Spilled liquids and grease wiped up at once.	
Nonslip floor wax.	
Back door and/or basement door securely fastened.	
Young children never left alone in the kitchen.	
No running and racing through allowed when you are working.	
Cords to frying pans, coffee pots, etc. out of reach of grasping hands.	
STAIRS AND HALLS	
Gates in place.	
Sturdy handrails.	
Stair carpeting securely tacked.	
No road blocks in halls.	
Well lit.	
No clutter sitting on steps.	
ADULTS' BEDROOMS	
The second leading site of poisoning accidents. Be especially careful about cosmetics and medicines.	

CHILDREN'S BEDROOMS	
Toys put away at night.	
All equipment sturdy and safe.	
Windows and screens secure, but can be easily opened in case of fire.	
Adequate fire escape provisions and training in use.	
Baby toys too big to swallow, free of splinters and small parts, all paints nontoxic	
BATHROOM	
Medicines, cosmetics, razor blades, and cleaning supplies kept out of sight and reach, preferably under lock and key.	
Light switches safe from water splashes or wet fingers, electrical appliances disconnected when not in use.	
Off limits to young children alone.	
Rubber mat and handhold in bath.	
Outside lock release for door.	
Children never left alone in tub or on bathinette.	
LIVING ROOM OR FAMILY ROOM	
Matches and lighters out of reach.	
Fireplace well screened.	
Rugs fixed so they cannot slide.	
Sewing equipment put away.	
Unused electric outlets covered - used ones out of reach.	
Hot radiators and pipes protected with guards.	
Lamps and furniture without sharp edges or corners. Decorations sturdy enough not to be pulled over easily.	
Poisonous or other dangerous plants out of reach.	
Liquor cabinet locked.	
PURSES (Your's and Others')	
Check the contents of your purse. Do you carry pills, a sharp instrument, makeup, pre-moistened towelettes (which can be lethal) or any other substance of potential danger?	
Make arrangements to place all visitors' purses up and out of reach of small children, such as on closet shelf.	
ATTIC AND BASEMENT	
Access stairs kept clear and safe for use, adequately lit.	
Paints, solvents, other chemicals safely stored in metal containers.	
Furnace and water heater securely guarded.	
No oily rags or litter.	
Dangerous tools disconnected, out of sight and reach.	
YARD	
Fenced for runabouts - or use playpen in yard.	
Protect infants who nap outside in a buggy with mosquito netting, check them frequently. Stop buggy naps when they have learned to pull up and rock the buggy violently.	
No large holes or other "booby traps".	

Pools fenced, gates locked when not in use.	
Drain small pools and use only under direct supervision.	
Driveway off limits for play or tricycle riding unless barrier is placed to street.	
No low-hanging clothes lines, no loose ropes.	
Yard policed for dangerous litter (scrap lumber, nails, glass, etc.), especially if your home is new.	
Play equipment strong enough to hold adults, swings with safe seats (leather or canvas, not wood or metal).	
Garden tools and mowing equipment put away, out of reach.	
Garage door closed and locked. If car is left out, car doors locked.	
All pesticides, fertilizers or other poisonous substances locked away.	
USUAL RECREATION OR PARK AREAS	
Play equipment sturdy.	
Supervision provided.	
If major streets must be crossed, is police officer or marshal available?	

UNFAMILIAR PLACES

Stores, movies and outdoor activities can provide opportunities for accidents just because they are unfamiliar and you have less control of the surroundings. You cannot be sure the department store mannequin is secure on its base, but you can hold hands and enforce a "look, but don't touch" rule in public places. Always establish a set of safety rules and precautionary measures when going on outings. Some of these may include: complete name tag pinned on each child with phone number and address, "what to do if lost" practice sessions, rules for holding hands, a first-aid kit, several dimes, and emergency phone numbers in car and/or purse.

CARS

In the car, rules apply to everyone, every time. Make sure your's and the children's seat belts are fastened and the doors are locked. Check the back door safety locks (get some if you do not have any), and open a window or vent, even in winter, unless your car is air-conditioned. Never leave children unattended in the car. Everyone must sit and remain seated while the car is moving. Everyone must keep head, hands, and possessions inside the car. No one may distract the driver by fighting, fussing or yelling. Apply the following rules: 1) No lollipops or popsicles; 2) No sharp edged or heavy toys; 3) No balloons, clothing, etc. allowed to obstruct the driver's view; and 4) Infants and young children ride only when in proper car restraints. These rules should be applied at <u>all</u> times -- absolutely no exceptions.

TRICYCLES AND BIKES

Tricycles and bikes are fun and provide good exercise but are dangerous unless children have been taught to use them safely. Stay with a child until he/she is sure of himself/herself and you are sure of him/her as a rider. Let the child know where he/she may and may not ride. Impress upon him/her repeatedly the dangers of driveways. Make it clear that there are to be no hazardous stunts --you are more impressed by common sense than by "look, Ma, no hands." Your training now will be used to good advantage, later--with skates and skateboards, skis and sleds, and eventually cars. It is an important area to get started in right.

BOTTLE OR BREAST FEEDING?
DECIDING WHICH IS BEST FOR YOU

We live in an age where freedom of choice is very much a fact in a great many areas of our lives. And, along with this freedom of choice comes pressure to choose what certain groups or individuals sincerely believe to be the best way. Whether to breast or bottle feed your baby may be one of those areas for you. You may find yourself desperately trying to sort out your feelings based on inconsistent statements made by various authorities such as Ilene Rice, B.S.N., who in her book Breastfeeding: A Headstart says "What should be unthinkable.... any mother who would not consider nursing her baby!!!" to Dr. Brazelton who in his book Doctor and Child declares, "Although I believe breastfeeding is better than bottle feeding, I am not extreme in my attitudes. If the need exists, I never hesitate to urge a mother to use an 'emergency' formula once or twice a day." to Virginia Pomeranz, M.D. who in her book, The First Five Years maintains that "A mother who wishes to breast feed her baby should receive encouragement from her doctor and family. The mother who prefers to use the bottle should not feel that she is guilty of some nebulous sin."; not to mention advice from well meaning relatives and friends.

We, in this discussion, will not take a stand for either method, other than the one reflected by the authors of Child Care who on the subject of breastfeeding state, "A natural and excellent way of feeding your baby. A rich source of satisfaction - but only if you really want and prefer to." - and on bottle feeding - "What matters most is that you and your baby have the same relationship as in breastfeeding. You want a warm, contented baby, cuddled, held close, and satisfied....Bottle fed or breast fed the same principles are involved: infant satisfaction along with the mother's satisfaction." And we might add, the father's satisfaction. We have listed some of the more commonly recognized advantages and disadvantages of each method, so that you can make this choice based on which method seems to best suit you and your baby's needs. When you are thriving as a parent, your baby will thrive as your child.

ADVANTAGES OF:

BREASTFEEDING

Baby receives "colostrum" the first few days of life. Important because it contains necessary minerals and important antibodies.

Breast milk contains everything a baby needs.

Baby tends to have fewer digestive upsets.

No preparation time, or need to sterilize equipment.

Less work and fuss when traveling with baby.

BOTTLE FEEDING

Baby's milk is independent of mother's diet.

Presents ideal opportunity for father to develop a close relationship with baby.

Father or other person can stand in for part of the 2:00 o'clock feedings.

The baby can be fed anywhere.

One less adjustment baby will need to make should the mother suddenly be unable to breast feed him.

ADVANTAGES OF: (Cont'd.)

BREASTFEEDING

Night feeding easier (no need to go to refrigerator, etc.)

No need for refrigeration or storage of formula.

Fosters the one-to-one situation required for a healthy attachment (bonding) with one central caregiver.

Baby less likely to contract meningitis or respiratory tract infections.

BOTTLE FEEDING

Mother can take any required medications without fear of affecting the baby.*

DISADVANTAGES OF:

BREASTFEEDING

Difficult to find privacy to feed the baby for mothers who are uncomfortable baring their breasts in public.

Sore and cracked nipples under some circumstances.

Mother must forego some foods while nursing which might affect the baby and specifically avoid alcoholic beverages.

More difficult for mother to get away for any length of time or to work full time.

Sometimes the amount of milk available does not coincide with the baby's needs.

Mother's health and well being may affect baby.

BOTTLE FEEDING

Baby does not receive the benefits from "colostrum" since no artificial substitute has been developed.

Greater tendency towards obesity in bottle fed babies.

Greater tendency towards gastro-enterites or stomach upsets (however, meticulous cleanliness should prevent this from happening).

Greater tendency towards ear infections.

Greater tendency towards viral infections.

Greater tendency towards suffering from allergies.

Greater tendency towards getting yeast infections.

Greater tendency towards having excretion problems (overly loose stools or constipated).

Greater tendency towards amino-acid deficiency.

Sometimes it is difficult to find formula that is suitable for a particular baby.

Greater tendency towards diaper rash.

*Drugs that will be passed to the baby via breastmilk in small amounts are: caffeine, nicotine, opiates, quinine, antibiotics, tranquilizers, vitamin C and laxatives.

Drugs passed in large amounts are: aspirin, alcohol, barbituates, bromides and ergot.

FEEDING MILESTONES FOR INFANTS*

Birth	Rooting and sucking reflex
2 Months	Moves head to food
4 Months	Recognizes bottle May place hands on bottle Poises mouth for food Accepts food from spoon
5 Months	Hands on bottle Can accept liquid from a cup (a sip at a time)
6 Months	Holds bottle with help Some chewing motions
7 Months	Expectant in food situation
8 Months	Holds bottle without help; may not replace bottle in mouth
9 Months	Holds bottle without help; can remove and replace bottle in mouth May feed self cracker Chewing is well developed Protrudes, lateralizes, and elevates tongue
12 Months	Finger feeds part of meal Bites and chews food well Brings empty cup to mouth Holds spoon, poor control Drooling controlled

*MN Department of Health, Nutrition Unit, 1981

RECOMMENDED SERVINGS PER DAY

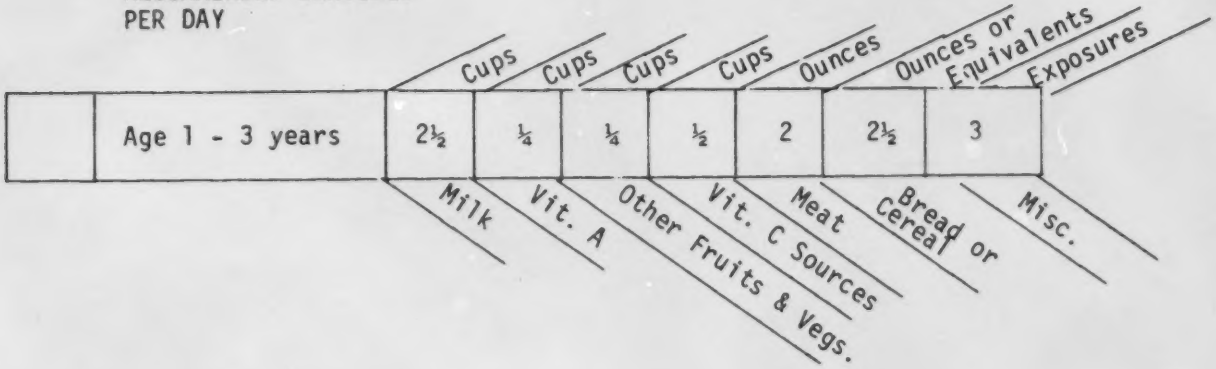
		Formula (Iron-fortified) Ounces	Vegetables Tablespoons	Fruit Tablespoons	Juice Ounces	Meat Tablespoons	Cereal Tablespoons	Misc. Not Recommended
INFANTS	0 - 1 month	20 22						
	1 - 2 months	22 29						
	2 - 3 months	26 30						
	3 - 4 months	26 37						
	4 - 5 months	36 40					3-5	
	5 - 6 months	23 35	2-4	2-4			4-6	
	6 - 7 months	26 35	4-6	6-8	2-4		4-6	
	7 - 9 months	28 32	4-6	6-8	4	2-4	4-6	
	9 - 12 months	28 32	4-6	8	4	4-6	4-6	
	Servings Per Day							
	+, -, or OK							

MN Department of Health, Nutrition Unit, 1981

FEEDING MILESTONES FOR TODDLERS*

12 Months	Finger feeds part of meal Bites and chews food well Brings empty cup to mouth Holds spoon; poor control Drooling controlled
15 Months	Holds spoon, pronated position Attempts to feed self with spoon Helps hold cup in drinking
18 Months	Drinks from cup, two hands holding (may tilt cup excessively) Needs help in releasing cup and glass Feeds self part of meal with spoon (may overturn spoon) Can fill spoon, insecure grasp (held near end of handle) Some difficulty getting spoon to and in mouth
2 Years	Pronated position on spoon secure (mid-handle) Spoon to mouth without overturning Feeds self independently, but may need help (spills, and is messy) Drinks from small glass, one hand holding
2½ Years	May begin supinated grasp, insecure "Ritualism" in eating (Less messy, some may be "spotless") Can pour from pitcher Can get drink at faucet May spear with fork
3 Years	May use fork for eating, spoon well controlled Grasp frequently is supinated but may be insecure

RECOMMENDED SERVINGS
PER DAY



*Adapted from materials provided by MN Department of Health, Nutrition Unit, 1981.

WHAT IS A SERVING?*

	Kind of Food	1 Year	2-3 Years
Vegetable and Fruit	Cooked Vegetables	2 Tbsp.	3 Tbsp.
	Raw Vegetables	1 or 2 pieces	2 or 3 sm. pieces
	Fruit	1/4 cup	1/3 cup
	Juices (citrus, etc.)	1/3-1/2 cup	1/3-1/2 cup
Bread and Cereal	Bread	1/2-1 slice	1 slice
	Cereal, Roll, Pasta	1/4 cup	1/3 cup
Milk and Cheese	Milk	1/2-1 cup	1/2-1 cup
	Cheese	1/4-1/2 oz.	1 oz.
	Cottage Cheese	1 Tbsp.	3 Tbsp.
Meat, Fish, Poultry, Beans	Lean, Edible, Cooked Meat	1 Tbsp.	2-3 Tbsp.
	Eggs, Medium	1	1
	Peanut Butter		2 Tbsp.
	Dry Beans		2 Tbsp.

*Adapted from materials provided by MN Department of Health, Nutrition Unit, 1981.

Transparency or Handout

RECOMMENDED FEEDING SCHEDULE--FIRST 12 MONTHS*

breast milk or iron-fortified formula	20 - 22	22 - 29	26 - 30	26 - 37	26 - 40	28 - 35	28 - 35	28 - 32	28 - 32+
Juice (OZ.)					*1 - 2	4			
Fruit (T)						1 - 2	6 - 8	6 - 10	½ c
Vegetable (T)						1 - 2	6 - 8	6 - 10	½ c
Meat (T)								2 - 4	4 - 6
Cereal (T)					2 - 4	4 - 6	4 - 6	4 - 6	4 - 6
Vegetable/Meat Dinner Hi Meat Dinner Desserts						NOT RECOMMENDED			

*From cup only to avoid long exposure of sugar to teeth and gums

**Solids not necessary until 6 months if infant breast-fed or on iron-fortified formula

NOTE: 1) Formula consumption decreases when solids increase.

2) Do not start cow's milk and meat at the same time--the renal solute load is too high.

*MN Department of Health, Nutrition Unit, 1981.

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Healthy Facts

Feeding your baby - the first year

Babies grow fast, especially during their first year. Their weight nearly triples and they grow in length about 10 inches. You can see that feeding your baby well is a very important responsibility.

Breastfeeding or bottlefeeding?

Both breastfeeding and bottlefeeding are good ways to feed your baby. The choice is yours.

Bottlefeeding

If you decide to bottlefeed, you will need to use an iron-fortified formula. These formulas are designed to be like breast milk, the ideal food for babies.

Regular (cow's) milk should not be fed to babies until they are one year old.

The kinds and amounts of protein, fat and sugar in cow's milk are harder for a baby to digest and use. Also, the amount of protein and salt is too high for most babies. Cow's milk lacks iron so its use can lead to anemia.

Choosing a Formula

Similac, Enfamil, or SMA are the popular brands of infant formula. All are good. Be sure, though, to choose a formula with added iron. This will help the baby build enough red blood cells to be healthy.

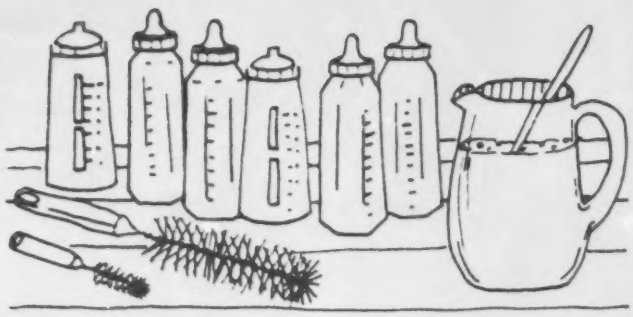
Powdered or liquid concentrate formulas are the best buy. Powdered formulas keep well, so are ideal for the occasional supplement given to breastfed babies. Pre-mixed, ready-to-feed formulas are quite expensive.

Preparing the Formula

You will need:

- bottles (about six 8-ounce and two 4-ounce plastic, glass or disposable)
- nipples (the NUK nipple is suggested since it promotes good tooth and jaw development)
- bottle and nipple brush
- a one quart container, a can opener and a spoon

It is all right to feed cold formula. If you wish to warm the formula, hold the bottle under the hot water faucet or heat it gently in a pan of water on the stove.



Cleaning the Bottles and Nipples

Sterilizing the bottles, nipples and equipment or using boiled water is not necessary if you follow these easy directions:

1. Scrub the bottles, nipples and caps with hot, soapy water using a bottle brush and a nipple brush. Rinse well with hot water and allow to air dry.
2. If liquid concentrate formula is used, wash off the top of the can. open it with a clean can opener and mix it with an equal amount of water. If powdered formula is used, mix one scoopful (included in the can) to two ounces of water while stirring.
3. Pour the amount of formula your baby usually drinks into the bottles. Cap and refrigerate them. (The can of formula may be stored, covered, in the refrigerator and used within two days.)

How Much to Feed

Breast fed babies will feed for about 15 to 20 minutes on each breast. A baby that seems satisfied after feedings and wets his or her diaper about six times during the day is getting enough to eat.

Bottle fed babies usually take three to four ounces per feeding or 20 to 24 ounces per day during the first month. This usually increases to 24 to 28 ounces during the second month and 28 to 32 ounces during the third month.

Feeding Your Baby

Sit down, relax and hold your baby while breastfeeding or bottlefeeding. Cuddling is as important as food for your baby's good growth. Never prop bottles: it may cause choking, ear infections and tooth decay.

Burp your baby at the middle and at the end of each feeding. To do this, gently rub or pat the baby's back while holding the baby over your shoulder or on your lap.

Throw away any formula left in the bottle. Do not save it for the next feeding since germs could grow it it and make the baby sick.

Feeding Schedule

All babies are different. Most formula fed babies are hungry every three to four hours. Since breast milk is so easily digested, breast fed babies may need to eat every two and a half to three hours. If you feel your baby is eating too often or not enough, check with your doctor, nurse or nutritionist.

Avoid Overfeeding!

Babies cry for many reasons other than hunger. Wet diapers, air bubbles, or being bored can make them cry too. Rather than always feeding your baby when he or she cries, try cuddling, singing or talking to the baby. Offer plain water with no sugar or honey added. Babies also have a sucking need, so try using a pacifier.

Do not feed more than 32 ounces of prepared formula per day without checking with your doctor, nurse or nutritionist.

Starting other foods

Breast milk or formula gives your baby all of the nutrition he or she needs until four to six months of age. We recommend that you not feed other foods before this time and that you check with your doctor, nurse or nutritionist before starting cereal or other foods.

Solid food fed too early does not help your baby sleep through the night. It may not be digested well and may cause colic or food allergies. And it may cause your baby to become overweight.

You can use either homemade or jarred baby food. Both will provide your baby with good nutrition.

Do not add extra sugar, salt or butter to the foods you buy or make for your baby. Babies do not need these. Remember, baby foods are made for babies, not for parents, so do not expect them to taste like the foods you eat.

When Your Baby Is Ready for Solid Foods (4 to 6 Months)

The most important point is to go slowly. Eating many foods at an early age does not mean that your baby is growing up. Add only one new food at a time. Then wait five days and watch for signs of allergy (wheezing, rash or diarrhea).

Feeding Your Baby Solid Foods

Always feed solid foods with a spoon (not in a bottle or with an infafeeder). Hold your baby or let the baby sit up in an infant seat.

Cereal (at 4 to 6 months)

Start with rice cereal (from the box). Mix one to two teaspoons of cereal with formula or milk in a small dish until it is thin and smooth. Gradually increase the amount of cereal until the baby is getting two to four tablespoons of cereal per day.

Fruits (at 5 to 6 months)

Choose plain food like applesauce, bananas, peaches and pears. Avoid high-calorie fruit desserts.

Vegetables (at 5 to 6 months)

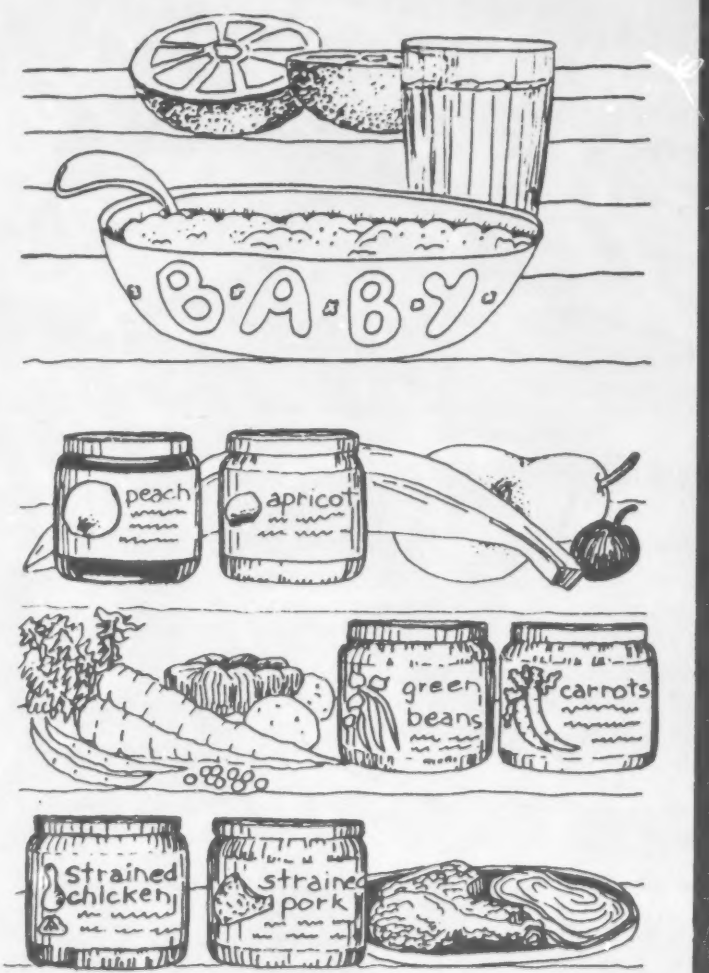
Choose plain vegetables like peas, carrots, green beans. Avoid vegetable-meat combinations.

Meats (at 6 to 7 months)

Choose plain strained meats like beef, chicken, turkey, veal and lamb. Vegetable-meat combinations and high-meat dinners do not contain as much protein and iron.

Juice (at 4 to 6 months)

Feed plain, natural fruit juices (without sugar). Wait for orange juice until your baby is at least six months old. Do not feed Kool-aid, Hi-C, Tang, or other sugary fruit drinks. Be sure that the juices that you give your baby are fortified with vitamin C.



Produced by the Minnesota Department of Health, based on materials of the St. Paul Maternal and Infant Care Program, 1981.

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UNIT 12 - B

NUTRITION DURING LACTATION

GOAL: To provide information on the principles of good nutrition during lactation.

OBJECTIVES:

A. Students will use the Basic Four Food Groups to plan one day's menus which meet the nutritional needs of the breast-feeding woman.

B. Students will give three advantages of breast-feeding and formula feeding.

OBJECTIVE A

Students will use the Basic Four Food Groups to plan one day's menus which meet the nutritional needs of the breast-feeding woman.

Activities

A. Distribute objectives students are expected to accomplish.

B. Distribute National Dairy Council's "Daily Food Guide."

C. Distribute "Feeding Your Baby With Love," MDH.

D. Show film "Feeding Your Baby," MDH.

E. Discuss nutrition during breast-feeding. Refer to the Basic Four chart.

1. Breast-feeding requires an additional 500 to 850 calories per day, 500 the first three months, 700-850 thereafter. Weight-reducing diets should be postponed until after breast-feeding.

2. Eat the recommended number of servings from each food group. Supplement with additional foods from each food group and "others" group.

3. Drink adequate fluids (two to three quarts per day).

F. Have students plan one day's menus that meet the Basic Four during breast-feeding. Include extra fluids such as juice, milk and water.

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*Guidelines for Expectant Parent Education, 1981 Edition, Minnesota Department of Health and Minnesota Department of Education. This curriculum is available from the Minnesota Curriculum Service Center, 3554 White Bear Ave., White Bear Lake, MN 55110. For further information, Metropolitan Area residents call 770-3943; outside Metro Area, call toll-free 800-652-9024.

OBJECTIVE B

Students will give three advantages of breast-feeding and formula-feeding.

Activities

A. Display poster, "Breast Milk is Best," part of a set of four posters ("Food for Health") from the Center for Science in Public Interest, 1757 S Street N.W., Washington, D.C. 20009 ($2.00 for the poster, $6.00 for the set).

B. Discuss advantages of breast-feeding.

1. Antibody transmission--baby can resist infection better.

2. Absorption of vitamins C, D, and iron is much better in breast milk.

3. Protein in cows' milk may cause allergies.

4. Lactalbumin is the main protein in breast milk, in contrast to casein in cows' milk. Lactalbumin is much easier to digest than casein. Therefore, a breast-fed baby has less stomach aches and diarrhea.

5. The amount of breast milk consumed is controlled by the baby. As a result, the baby is less likely to be overfed by a parent encouraging him to finish the bottle.

6. Human milk is cheaper than formula. Additional nutrients needed by the nursing mother can be supplied by extra amounts of regular food.

7. Close mother-baby contact following birth is important for "bonding."

8. Breast-feeding allows the mother to lose stores of fat accumulated during pregnancy; thus, her weight returns to normal more quickly than if she does not nurse the infant.

C. Breast-feeding for a few weeks is preferred to not breast-feeding at all. Working mothers may express milk by hand, refrigerate or freeze it and save it for feeding, or use an infant formula during the day.

D. The primary contraindication to nursing is if the mother is taking drugs. Drugs are absorbed into the milk and may harm the baby.

Other contraindications:

1. Breast disease (mastitis)

2. A profound aversion to it.

E. Mother should not take oral contraceptives while breast-feeding. The amount of breast milk may decrease, since estrogen and progesterone reduce milk production. Also, small amounts of hormones appear in the milk and may affect the baby.

F. When breast-feeding ask the doctor about supplementing baby's diet with vitamin D and fluoride at several weeks of age. The amount of flouride content of the local water supply will have a bearing on this. It should be pointed out that flouride is frequently included with other vitamins in a single supplement, and it is possible to give the infant excess flouride.

* *

MATERIALS

Handouts: A Guide to Good Eating
Reprints "Breast Feeding" from American Academy of Pediatrics

Visuals: Film "Breast Feeding--A Special Closeness"
Minnesota Department of Health
Film "Feeding Your Baby"
Minnesota Department of Health

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UNIT 12 - C

INFANT FEEDING

GOAL: To provide information on the basic principles of infant feeding--breast-feeding (see previous unit), formula feeding, introduction of solid foods, and use of homemade or commercial baby foods.

OBJECTIVES:

A. Students will name four basic types of formula.

B. Students will state criteria for choosing bottles and nipples for bottle feeding.

C. Students will name the first solid food to be introduced in infant's diet and give the age it should be introduced.

D. Students will state two advantages of homemade baby foods and commercial baby foods.

OBJECTIVE

Student will name four basic types of formula.

Activities

A. Distribute objectives.

B. Discuss infant formulas as an option to breast-feeding. (You may wish to mix and test a formula as demonstration to note that what "tastes good" to baby may not be what "tastes good" to mom).

1. Formulas contain all necessary vitamins. They are available with or without iron. Iron fortified formula is recommended for the first year of life.

a. Powdered formulas:
1) least expensive per bottle
2) must be mixed with warm water
3) may be made one bottle at a time
4) least waste to supplement breast-fed infant
5) does not need to be refrigerated until reconstituted, so O.K. for travel in dry form

b. Concentrated formulas:
1) slightly more expensive than powder
2) may be mixed with warm or cold water
3) may be made one bottle at a time if opened can is refrigerated
4) more waste if used to supplement the breast-fed infant
5) must be refrigerated after opening

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*Guidelines for Expectant Parent Education, 1981 Edition, Minnesota Department of Health and Minnesota Department of Education. This curriculum is available from the Minnesota Curriculum Service Center, 3554 White Bear Ave., White Bear Lake, MN 55110. For further information, Metropolitan Area residents call 770-3943; outside Metro Area, call toll-free 800-652-9024.

c. Ready-to-feed:
   1) very expensive
   2) no mixing--use right from can
   3) more waste if used to supplement breast-fed infant unless the smaller (6 oz) cans are used, which are more expensive
   4) must be refrigerated after opening

d. Disposable bottles
   1) most expensive
   2) convenient--no mixing--good for travel
   3) less waste for supplementing the breast-fed infant
   4) no refrigeration necessary until after opening

2. Follow directions exactly. An overly concentrated formula places a heavy load on the kidneys, and the extra calories may result in obesity. An overdiluted formula may impair a baby's growth.

3. Cow milk is not recommended for infants under one year old. It is especially not recommended for infants under six months of age. Heat treated cow's milk (evaporated milk) is sometimes used but is low in iron and, when mixed 1:1, has a renal solute load as high as regular cow's milk. It is, however, less likely to cause occult blood loss than regular cow's milk. Two percent or skim milk can lead to malnutrition if used before one year of age due to lack of essential fatty acids and calories which may cause an increase for volume of food intake leading to overeating.

4. Low calorie infant formula for the older infant contains iron with a calorie content between skim milk and whole milk or regular infant formula, but with an adequate level of essential fatty acids.

C. Formula preparation.

1. Terminal sterilization.

   a. Mix the bottle formula, then sterilize and refrigerate.

2. Aseptic

   a. Boil bottles and nipples
   b. Mix formula
   c. Pour into bottles and refrigerate

3. Single bottle

   a. Wash and rinse bottle and nipple
   b. Mix appropriate amount of water and formula in bottle and feed immediately

4. Non-sterile multiple bottles

   a. Wash bottles and nipples and rinse
   b. Mix formula
   c. Pour into bottles, cap and refrigerate

*This is the most popular method, see "Feeding Your Baby with Love" page 10-11. However, it is not recommended where environmental conditions warrant sterilization.

OBJECTIVE B

Students will be able to state criteria for choosing bottles and nipples for bottle feeding.

Activities

A. Have various types of nipples available to demonstrate formula flow and strength of nipple from soft to firm.

B. Discuss purpose of two basic nipples.

1. Regular (NUK or other) that is fairly firm and gives a constant "drip" when inverted.
   a. need to be replaced regularly
   b. too soft nipple may not give enough sucking

2. "Premie" - cross cut and soft for ease of sucking for infants with a weak suck. (Caution about using this with an average infant since they may not get enough sucking and may overeat.

C. Have various bottles available for demonstration.

D. Discuss the advantages and disadvantages of basic types:

1. Glass
   a. easier to clean
   b. breakable is less likely to be given to the older infant in a crib and thus may reduce tendency for "Nursing Bottle Mouth"

2. Plastic
   a. hard to keep clean--get scratched and stained
   b. unbreakable so more likely to allow infant to hold own bottle and/or sleep with bottle. Therefore, open to possible "Nursing Bottle Mouth"
   c. Meltable

3. Disposable nurser with plastic bags
   a. Must use bags only once (cannot effectively clean used bags)
   b. nipples may come off in use in some models
   c. good for travel

OBJECTIVE C

Students will name the first solid food to be introduced in infant's diet and give the age it should be introduced.

Activities

A. Discuss when to introduce solid foods.

1. Opinions differ regarding the optimal age to introduce solid foods. Most pediatric authorities agree that solid food is unnecessary during the first three months of life.

2. The needs of infants are best judged on an individual basis. Large, rapidly growing infants may need solid food, in addition to formula or breast milk, at an earlier age than small, premature infants. Therefore, age should not be used as the sole factor in determining need for solid food. When an infant is taking 32 ounces of formula in 24 hours and still seems hungry, it is generally time to add cereal to the diet.

3. Developmental readiness (head control, tongue thrust, etc.) are important factors to consider when adding solids.

4. Remember, learning to eat from a spoon is initially more important than volume of solids consumed. Therefore, devices such as the "infa-feeder" are not recommended and may even be dangerous by causing choking and/or over feeding.

5. The infant's store of iron is depleted after the first three or four months of life. Solid foods, especially baby cereals, replenish this iron.

6. Mothers should be cautioned against sweetening foods with sugar or letting baby have long access to the bottle. The sugar in milk or sugar water can lead to tooth decay.

7. The following is a flexible pattern for adding solid foods to the infant's diet. One new food should be introduced at a time, allowing four to five days before adding another.
   a. 4-5 months. Start with warm infant cereal, fortified with iron; use one variety for a week or so, and then change to another variety. Start with one to two teaspoons at a time, and dilute it with formula to make a thin consistency. Best begin with rice as the least likely to cause allergy. Other types are barley, oatmeal, cream of what, and grits. These cereals supply iron and introduce new textures and flavors.
   b. 5-6 months. Begin cooked, strained fruits or vegetables. Don't add salt or sugar or give sweetened fruit desserts. Bananas are the only fruit which need not be strained. Simply mash them with a fork. These fruits add vitamins and texture and flavor.
   c. 6-7 months. Continue adding new fruits and vegetables. Do not use canned fruit juices or vegetables as the lead content may be inappropriate for infants.
   d. 7-9 months. Gradulally change foods to finely chopped foods; begin plain potatoes and toast. Start adding meats. (Note that the texture may be a bit sticky for baby at first.)
   e. 9-12 months. The one-year-old baby should consume approximately one egg yolk (one-third jar), seven tablespoons of vegetables, one-half cup vitamin C fruit juice, six tablespoons fruit, and one-half cup of cereal each day. No more than three to four cups of milk per

day--if a baby takes more than this, he will fill up on milk and won't eat enough solid foods which supply other nutrients. Usually appetite decreases after one year of age. Start egg white and whole wheat products (no wheat berries), cooked greens.

OBJECTIVE D

Students will state two advantages of homemade baby foods and commercial foods.

Activities

A. Discuss advantages of homemade baby foods.

1. More nutritious. Better way of knowing the nutritive contents. Contains no added salt, sugar, or modified starches. You can now buy commercial baby foods without added salt, but you'll still find added sugar and starches. The added sugar adds nothing but empty calories and may stimulate baby's preference forsweet foods, and the added modified food starch replaces a substantial portion of the nutritious ingredients in the jar.

2. Less expensive (this may be questionable when labor is considered).

3. Save energy--use leftovers; save jars and extra trips to the store.

4. Introduces baby to foods actually eaten in the home.

B. Discuss advantages (and precautions) of commercial baby foods.

1. easy

2. convenient

3. can store at room temperature until opened so easier when travel

4. can have foods for baby when the family meal is not appropriate for infants

5. Do check the safety seal
Do Not feed from the jar
Do remove food from jar for heating
Do store unused portions covered in refrigerator

C. Show labels from a variety of commercial baby foods. Explain how the ingredients are listed in order of predominance. Some companies now label the percentage of added sugar or modified food starch.

D. Discuss how to make homemade baby foods.

1. Use well-cooked meats, vegetables, and stewed or soft fruits. Cook in a small amount of water to preserve nutritional value. Canned applesauce and juices are fine as is.

2. Don't add salt or sugar.

3. Use a blender, food mill, or baby food grinder to puree the food to soft consistency. A blender incorporates more air which may destroy some vitamins. It is more convenient to use a small blender jar.

4. Store prepared foods in individual servings in a plastic bag after freezing in a ice cube tray in the freezer, or in sterile jars. Then, remove one serving when needed.

5. Make sure that utensils you use and the area in which you work is clean. Wash food carefully, trim peels and fat, and remove seeds.

6. Choose a variety of foods--fruits and juices, vegetables, meats and cereals.

7. Show mothers some recommended recipe books on preparing homemade baby foods (see references).

8. Instructor may want to hand out following pamphlet , Voichik, Jane and Nancy Gadzuk. Preparing Baby Food at Home. Madison, Wisconsin: Agriculture Bulletin Building, 1535 Observatory Drive, 53706, B2705, 1975. Two pages, five cents plus postage.

E. Demonstrate how to use a baby food grinder.

F. Discuss the use of commercial foods.

1. Choose the plain items--avoid combinations.

2. Clean the jar carefully before opening. The vacuum seal, when broken by twisting the jar lid, can suck dirt and debris into the food.

3. Learn to read labels--this will help avoid unnecessary or harmful ingredients.

* *

MATERIALS

Handouts: Objectives
National Dairy Council's "Daily Food Guide"
Pamphlet on "Preparing Baby Foods at Home"

Visuals: Film "Feeding Your Baby with Love"
Film on infant feeding
Poster--"Breast Milk is Best"
Show labels from commercial baby foods (baby cereal boxes, label from combination dinner, label from a plain item)
Demonstrate using baby food grinder
Recipe books on preparing homemade baby foods

* *

EVALUATION: Oral quiz to determine if objectives were met

INSTRUCTOR REFERENCES

1. Fomon, Samuel J., M.D., et al. Recommendations for Feeding Normal Infants. Pediatrics for the Clinician. Vol. 63 No. 1, January 1979.

2. Current Infant Feeding Practices. Dairy Council Digest. Vol. 51 No. 1, January/February, 1980.

3. Fomon, Samuel J., M.D. Infant Nutrition, second edition. W. B. Saunders Co., Philadelphia, 1974.

4. Lambert-Lagace, Louise, R.D. Feeding Your Child. Habitex Books. Collier-Macmillan Canada, Ltd. Cambridge, Ontario.

5. Aykroyd, Wallace R., M.D. "Is Breast Feeding Best for All Infants Everywhere?" Nutrition Today, Jan/Feb 1977, p. 15.

6. "Salt Intake and Eating Patterns of Infants and Children in Relation to Blood Pressure," American Academy of Pediatrics, Committee on Nutrition, Pediatrics Vol. 53:115, 1974.

7. "On the Feeding of Supplemental Foods to Infants," American Academy of Pediatrics, Committee on Nutrition, Pediatrics, June 1980, pages 1178-1180.

8. "Are Baby Foods Good Enough for Babies?" Consumer Reports, September 1975.

9. Eiger, Marvin S., M.D. and Sally W. Olds. The Complete Book of Breast Feeding. New York: Workman Publishing Company, Inc., 1972 (pbk: New York: Bantam Books, 1973).

10. Foman, S. F. and L. N. Thomas. "Acceptance of Unsalted Strained Foods by Normal Infants," Journal of Pediatrics 76:2, page 242, 1970.

11. Ishida, M., U. Evers and P. Ishida. "Introducing Solid Foods to Infants," Journal of Nursing, September/October 1973.

12. Jelliffe, Derrick B., M.D. and E. F.Jelliffe. "Breast Feeding is Best for Infants Everywhere," Nutrition Today, May/June 1978.

13. Jelliffe, Derrick B. and E. F. Jelliffe. "Current Concepts in Nutrition," New England Journal of Medicine 297:17, 912-917, October 27, 1977.

14. Lakdawala, D. and E. Widdowson. "Vitamin D in Human Milk," Lancet 1:8004, 167-168, January 22, 1977.

15. McDonald, Linda. Baby's Recipe Book. South Brunswick, New York: A. S. Barnes and Company. London: Thomas Yoseleff, Ltd., 1972.

16. Minnesota State Nutrition Council, Maternal and Infant Committee. Guidelines on Nutrition Management (1) Family Planning, Pregnancy, and Lactation ; (2) Infancy; (3) Infant Formulas. Price $1.00 plus 50 cents for postage and handling per order. Send requests to Irene Alton, Nutritionist, St. Paul Maternal and Infant Care Project, 640 Jackson Street, St. Paul, 55101.

17. Pipes, Peggy L. Nutrition in Infancy and Childhood. St. Louis: C. V. Mosby Company, 1981.

18. Pipes, Peggy L. "When Should Semi-Solid Foods be Fed to Infants?" Journal of Nutrition Education 9:2, page 57, June 1977.

19. "The Relationship of Nutrition to Brain Development and Behavior," Nutrition Today, July/August 1974, page 12.

20. Stoka, Rose E. "The Right Formula for the Right Infant: Making Sense of Infant Nutrition," Maternal Child Nursing, March/April 1977, page 101.

21. White Paper on Infant Feeding Practices. Washington, D.C.: Center for Science in the Public Interest, 20036, 1974.

NUTRITION SERVICES*

Nutrition services are varied and scattered. A list follows of the most available resources. More help in location of nutrition resources can be obtained from the Minnesota Department of Health, 717 Delaware Street S.E., Minneapolis, Minnesota 55440. There may be a fee for some services.

A-Local Dietitians - name may be obtained from hospital or nursing home. List is also kept at the Minnesota Depratment of Health (612) 296-5484. Twin Cities area has a Speakers Bureau, 373-3772.
B-Minnesota Department of Health - Nutrition Unit (612) 296-5279.
C-Services for Children with Handicaps Nutritionist (612) 341-7565.
D-Agriculture Extension
1. Nutrition specialists at state level (612) 376-4663.
2. County extension agents in many counties (contact county offices, extension services).
3. Some counties have expanded food and nutrition education program.

E-Utility Company Home Economists - (contact local gas and/or electric company).
F-Local Colleges may have faculty or students available from nutrition programs. Some colleges to consider are:
1. Southwest Minnesota State University, Marshall.
2. Normandale Junior College, Bloomington.
3. University of Minnesota, Minneapolis, St. Paul.
4. St. Catherine's College, St. Paul.
5. St. Scholastica College, Duluth.
6. College of St. Benedict, St. Joseph.
7. University of Minnesota, Crookston.
8. Mankato State University, Mankato.

G-Indian Health Service, Bemidji (218) 751-1210.
H-SEMCAC, Inc., Rushford (507) 864-7741.
I-Any local WIC Program.
J-County Nursing Services or County Health Departments may have dietitians or nutritionists.
K-Dairy Council of Minnesota, 2015 N. Rice, St. Paul, MN 55113 (612) 488-0261.
L-Food and Drug Administration, 240 Hennepin Ave., Minneapolis, MN 55401 (612) 725-2778.
M-Major Supermarket Chains in Minneapolis/St. Paul (Byerly's, Jerry's, Super Valu) employ home economists and/or registered dietitians.

TYPICAL NUTRITION PROBLEMS AND SUGGESTED RESOURCES

TYPICAL NUTRITION PROBLEMS AND SUGGESTED RESOURCES

1. Modified diet counseling A, B, C, G, H
2. Normal nutrition counseling A, B, C, D, F, G
3. Recipe suggestions D, E, M
4. Food budgeting counseling D, M
5. Menu planning A, B, C, D, F, F, G, H
6. Food preparation counseling D, E, F, M
7. Food preservation D, E, F, H
8. Children feeding problems B C, D, G, H
9. Food supplements and nutrition education for "at risk" women, infants and children
10. Nutrition education materials B, D, K, L

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*Minnesota Department of Health, Nutrition Unit, 1981

NUTRITION INFORMATION*

Minnesota Department of Health
717 S.E. Delaware Street
Minneapolis, MN 55440

1. A-3 Yellow order cards
2. N-62 Snack Sheet
3. N-64 Your Special Need for Iron
4. N-65 Healthy Facts - Iodine
5. N-66 Healthy Facts - Vitamin D
6. N-69 Health Facts - Fluoride
7. N-73 Calcium
8. N-74 Vitamin A
9. N-75 Vitamin C
10. N-67 Nutrition and Your Health - Dietary Guidelines for Americans
11. N-77 Healthy Facts - Feeding Your Baby - The First Year

Dairy Food and Nutrition Council
2015 North Rice Street
St. Paul, MN 55113 Telephone: 612-488-2015

1. Guide to Good Eating
2. Hypervitaminosis
3. Vitamin Facts
4. Vegetarian Nutrition
5. Food for You - Partners in Growth During Pregnancy
6. Food - From Birth to Birthday
7. Dairy Council Digest (free bimonthly newsletter)

Agricultural Extension Service
University of Minnesota
St. Paul, MN 55108

1. A Guide for Planning Your Daily Food Needs
2. Food for the Teenager During Pregnancy
3. Nutrition Sources - An Analysis of Validity

American Dietetic Association
430 North Michigan Avenue
Chicago, IL 60611

1. Meal Planning With Exchange Lists
2. Meal Time! Happy Time!

Documents Division
First Floor
117 University Avenue
St. Paul, MN 55155

1. Feeding Your Baby With Love (1982 - there will be a charge)
2. 1979/80 Audio Video Resources of State Agencies ($4.50 plus tax)

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*Minnesota Department of Health, Nutrition Unit, 1981

REFERENCE MATERIALS*

Suggested Handouts

1. "Be Good to Your Baby Before It is Born" March of Dimes.
2. "Partners in Growth" and "From Birth to Birthday" Dairy Food and Nutrition Council.
3. "A Guide to Good Eating" Dairy Food and Nutrition Council.
4. "Your Special Need for Iron" Minnesota Department of Health (N62).
5. "Good and Bad Nutrition References" Minnesota Department of Health.
6. "Recipes for Healthy Babies" March of Dimes.
7. "Drugs, Alcohol and Tobacco Abuse During Pregnancy" March of Dimes.
8. "Feeding Your Baby With Love" Minnesota Department of Health.

Suggested Audio-Visual Aids

1. "Great Expectations" (movie) Minnesota Department of Health or March of Dimes.
2. "Inside My Mom" (filmstrip and tape) March of Dimes.
3. "Breast Feeding - A Special Closeness" Minnesota Department of Health.
4. "Healthy Mother, Healthy Baby" Dairy Food and Nutrition Council.
5. "Feeding Your Baby" Minnesota Department of Health.

Suggested Handouts Especially for the Pregnant Adolescent

1. "Why Not Stay Healthy While You're Pregnant" (Series of 7) Agriculture Extension Service.
2. "Inside Your Body - Inside Your Head" March of Dimes.
3. "Hello World" (cookbook) March of Dimes.
4. "Food for the Teenager During Pregnancy" U.S. Department of Health, Education and Welfare.

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*Minnesota Department of Health, Nutrition Unit, 1981.

ADDRESS LIST OF RESOURCES*

1. March of Dimes
   Box 2000
   White Plains, New York 10602

   or

   Local Chapters (in telephone book)

   District - Central

   Jim Swanson 361-2291
   6701 Penn Avenue South
   Richfield, MN 55423

   - Northern

   Brian Hanson 252-1142
   25 - 15th Avenue South
   St. Cloud, MN

2. Ross Laboratories (for growth grids for pregnancy and infants and children) and pamphlets. Contact your local hospital for the representative nearest you.

3. Mead Johnson (Infant/child growth grids, pamphlets, flip charts on infant feeding).

4. Dairy Food and Nutrition Council
   Hillsborough Office Complex, Suite 220
   3253 North Rice Street
   St. Paul, MN 55113

5. Minnesota Department of Health
   Health Education
   717 S.E. Delaware Street
   Minneapolis, MN 55440

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*Minnesota Department of Health, Nutrition Unit, 1981.

NUTRITION BIBLIOGRAPHY*

RECOMMENDED

Deutsch, Ronald M. The New Nuts Among the Berries. Bull Publishing, Palo Alto, Calif., 1977.

Deutsch, Ronald M. The Family Guide to Better Food and Better Health. Creative Home Library, Meredith Corporation, Des Moines, Iowa, 1971. Pbk Bantam Books.

Deutsch, Ronald M. Realities of Nutrition. Bull Publishing, Palo Alto, California.

Ferguson, James M., M.D. Habits, Not Diets: The Real Way to Weight Control. Bull Publishing Co., Palo Alto, Calif., 1976.

Gifft, H. and M. Washbon. Nutrition, Behavior and Change. Prentice-Hall, Inc., Englewood Cliffs, N.J., 1972.

Herbert, Victor, M.D., J.D. Nutrition Cultism. George F. Stickley Co., 1980.

Ikeda, Joanne P., R.D. For Teenagers Only: Change Your Habits and Change Your Shape. Bull Publishing Co., Palo Alto, Calif., 1978.

Lambert, Lagace Louise. Feeding Your Child. Collier-MacMillan Canada Ltd., 539 Collier-Macmillan Drive, Cambridge, Ontario N I R 5W9.

Mayer, Jean. U.S. Nutrition Policies in the Seventies. W. H. Freeman and Co., San Francisco, 1973.

Mayer, Jean, Ph.D. Overweight: Causes, Cost and Control. Prentice-Hall, Inc., Englewood Cliffs, N.J., 1968.

Nash, Joyce D., Ph.D. Taking Charge of Your Weight and Well Being. Bull Publishing Co., Palo Alto, Calif., 1978.

National Research Council. Recommended Dietary Allowances. Ninth Ed. Food and Nutrition Board, National Research Council, National Academy of Sciences Washington, D.C., 1980.

Robertson, Laurel, et al. Laurel's Kitchen. Bantam Books, 1978.

Smith, Nathan. Food for Sport. Bull Publishing Co., Palo Alto, Calif., 1976.

Solomon, Neil, M.D. The Truth About Weight Control. Dell Publishing Co., Inc., New York, 1973.

U.S. Dept. of Agriculture. What's to Eat? The Yearbook of Agriculture. Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 1979.

Worthington-Roberts, et al. Nutrition in Pregnancy and Lactation. The C. V. Mosby Co., St. Louis, Missouri.

*Minnesota Department of Health, Nutrition Unit, 1981.

NOT RECOMMENDED

Atkins, Robert C., M.D. Dr. Atkins Diet Revolution. Bantam Books, New York, 1973.

Crenshaw, Mary Ann. The Natural Way to Super Beauty. David McKay Co., Inc., New York, 1974.

Davis, A. Let's Get Well. New York: Signet Books, 1970.

Davis, A. Let's Eat Right to Keep Fit. Signet Books, New York, 1970.

Davis, A. Let's Have Healthy Children. Signet Books, New York, 1970.

Davis, A. Let's Cook it Right. Signet Books, New York, 1970.

These books are often a confusing mixture of fact and fiction.

Dufty, Wm. Sugar Blues. Warner Books, 1975.

Fredericks, C. Dr. Carlton Frederick's Low Carbohydrate Diet. Award Books, New York, 1965.

Nazel, Judy. The Beverly Hills Diet Book. MacMillan Publishing Co., Inc., 1981.

Rodale, J. I. and Staff. Our Poisoned Earth and Sky. Rodale Books, Inc., Pennsylvania, 1964.

Smith, Lendon, M.D. Feed Your Kids Right: Dr. Smith's Program for Your Child's Total Health. McGraw-Hill, 1980.

Stillman, Irwin Maxwell, M.D. The Doctor's Quick Weight Loss Diet. Dell Books, New York, 1967.

Things To Do For Baby and You

378

DEAR PARENTS,

Things to Do for Baby and You was written to be used:

- As a tool to help you "really tune in" to your baby; to enhance your ability to catch those teachable moments. It may help you to zero in on cues that may, for example, say, "I need more time to check this box out. Please don't insist that I play with the new $10 educational toy that came in it. I'll do that later." We also hope it will help make your experience as a parent richer and more exciting as you begin to notice and appreciate all the finer nuances of your baby's character and abilities along with the more obvious milestones in his/her development.

- As a list of suggested ideas for toys and activities that you and your baby can enjoy together throughout his/her first two years.

- As a guide and constant reminder that your baby is unique and that he/she will develop in his/her own way, using his/her own style and at his/her own rate. (You will notice that there is a lot of leeway provided for recording when he/she might be doing certain things.)

- As a tool to help you define when to seek professional guidance. You will make that decision if your observations and knowledge about normal differences in children's development suggests areas of delay which may require special attention in order to guide your baby to his/her full potential.

You may wish to design your own growth and development books, choosing the ideas that appeal to you from this and adding ideas of your own, such as inserting pictures of your baby showing his/her progress pictorially as well as in diary form. But however you do it, your baby will appreciate the effort you made to record details of his/her "baby years." As he/she gets older (three or four), this will probably be one of his/her favorite books. Be sure to laminate it with clear contact paper so it will last a long time!

Things to Do for Baby and You

Birth to 24 months (more or less)

Being touched and caressed, being massaged, is food for the infant. Food as necessary as minerals, vitamins, and proteins.

Fredrich Leboyer, Loving Hands

There, there, I'll hold you until you feel better.

HOW CAN I TELL WHEN MY BABY WANTS TO PLAY?

Your baby is a wonderful and unique individual, who will in his/her way, let you know when he/she feels like talking, playing or just rocking together. But, before he/she can communicate what he/she would like from you, it is important that you, as a parent, recognize and understand what is referred to as the newborn's states of attention.

SO, WHAT ARE THE BABY'S "STATES?"

Following is a list of observable "states" (Column #1) and some suggestions (Column #2) on how you may best take advantage of each of these "states" while helping your baby do his/her share in building your relationship.

BABY'S STATES	AND WHAT'S A PARENT TO DO?
Regular or Deep Sleep Regular breathing, eyes closed, no eye movements, all muscles very relaxed, but may exhibit startle reaction (startle reflex).	Just relax and enjoy it. This time should be for yourself; but, if you are all caught up, you may wish to take some of this time to notice all the special things about your baby.
Irregular or Light Sleep Rapid eye movements (REM) often noticeable under closed lids, alternates between rapid and slow breathing, random movements of face, limbs and trunk, may smile, frown, feel lips with tongue, and gently stir or twist body.	Prepare to spend some time with your baby shortly as he/she is preparing to wake up.
Drowsy Imtermittently opens and closes eyelids, eyes may appear unfocused or glassy sometimes rolling upward. This is an intermediate state between sleeping and waking.	Let your baby move on to the next state (usually into Regular/Deep Sleep or Alert Inactive). He/She will not be able to respond to any activity while in this state.
Alert Inactive Eyes open, bright and focused, quiet (does not smile, grimace or make many movements) but tries to follow specific sounds and sights by moving eyes and head. Awake Active Face, head, limbs and trunk in high motion, eyes open, and skin may be flushed from exertion.	These seem to be the best "states" for infant learning from the point of being able to deal with or notice things in the environment. Talk to, touch, smile at, or give your baby a toy to focus on. Follow your baby's cues. You'll notice that as you catch one another's attention you will share a brief interaction and then slow down, stop, and begin the interaction over again, or with a little variation which you both seem to enjoy. This cycle pattern may repeat itself several times a minute. When the baby no longer wants to play he/she will withdraw, look away, or if feeling frustrated, begin to whimper or cry. Then it's time to stop. This has come to be known as "The Mother-Baby Dance" but

BABY'S STATES	AND WHAT'S A PARENT TO DO?
	Daddy and baby can dance just as beautifully.
Crying or Fussy May cry real tears, vigorous body movements, i.e., kicking and handsucking, especially before meals.	When your baby is fussy and you know he/she is not crying from hunger or pain you may wish to try the following to calm him/her: (a) show your face and smile at the baby. (b) talk to baby in a low, soothing, rhythmic voice. (c) place a hand on baby's chest. (d) gently restrain one arm (across chest as in fetal position). (e) gently restrain both arms. (f) pick up and hold, rock and talk to baby. (g) bundle/swaddle--wrap securely in receiving blanket. (h) offer an approved pacifier. Important Note: When the baby attempts to settle him/self/herself by placing thumb or fist in his/her mouth, be pleased that he/she is resourceful enough to find a way to sooth himself/herself. When he grows older and finds other ways to sooth himself/herself, he/she will stop.

Your baby needs to be recognized by you as an individual. As early as the age of two months, the infant is aware of your responses to him/her. Watch him/her as you lean over the carriage, and he/she catches a glimpse of your face. What joy there is in his/her sudden recognition of another human being! If you make little bubbling sounds to him/her, watch how his/her mouth puckers up as he/she tries to imitate them. You are providing a "responsive environment" that makes the baby know that he/she matters.

Betty Rowan, Tuning in to Your Child

HOW DOES THE BABY LEARN?

Most parents wonder "How can I give my baby the best possible beginning in life?" When they look around for answers they often find conflicting advice. Some people suggest a structured curriculum from the moment of birth, spending so many minutes a day talking to the baby, so many minutes a day showing him/her interesting patterns and so forth. At the other extreme, advice-givers recommend leaving the baby alone so he/she can learn by himself/herself. Each of us must choose the style of nurturing our child's development which seems to best suit our own and our baby's temperament and inner nature. This requires that we become good observers of ourselves and of our baby; that we clarify the goals we wish to attain as our baby's first educator; and that we educate ourselves as thoroughly as possible about normal growth and development of young children.

Even though the "experts" do not agree on a preferred style of nurturing, there is general agreement on the following facts relating to how children learn. An understanding of these facts may serve as a helpful guide as you define the method of learning together that seems best for you and your baby.

The baby learns best when he/she is attending to something which he/she is really interested in. In fact, he/she has the ability to totally tune / shut out anything that he/she is not interested in at the moment. It is, therefore, important that parents be good observers, and have an understanding of baby "states" and cues. Those skills can mean the difference between a fruitful learning time together or a frustrating one.

It is, also, important that the baby's concentration on a task not be disturbed. At first he/she needs to become familiar with the characteristics of everything in his/her environment. Next he/she has to figure out how the various elements in the environment work and how he/she can act upon them. Baby does this by feeling, looking, banging, poling, dropping, throwing, biting, etc. over and over.

The baby learns best through first-hand experiences. This means that parents must be careful not to do for the baby anything that he/she is in the process of, or about to do himself/herself. It also means that one of the greatest gifts a parent can give the baby is patience.

The baby learns from his/her mistakes as well as from his/her successes. It is essential that he/she be allowed to try things even when the adult, based on his/her past experiences, can predict that it will not work. This allows the baby the opportunity to develop the skills of making future predictions based on his/her developing a repertoire of past experience.

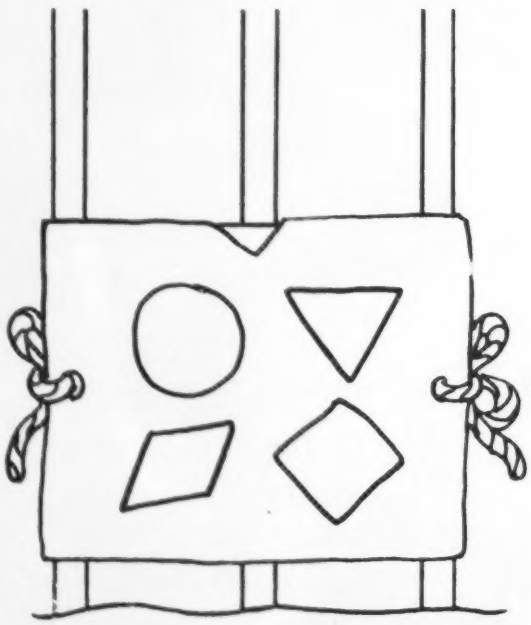
The baby learns from modeling. He/She loves to mimic what he/she sees others do. If the adult seems to be enjoying an activity, the baby will soon want to try it too. Let him/her observe and experiment; but never demand perfection, as that will only discourage him/her from trying at all.

The Things We Did Together Birth to three mos. (more or less)

- You responded to the sound of a _____ (rattle, whistle, etc.) by _____ (body language) at _____ (days, weeks) s old.
- You responded to the sound of my voice by _____ (describe body language).
- You turned towards the sound of _____ (rattle, voice, etc.) at _____ s old.
- Your favorite thing to look at was _____.

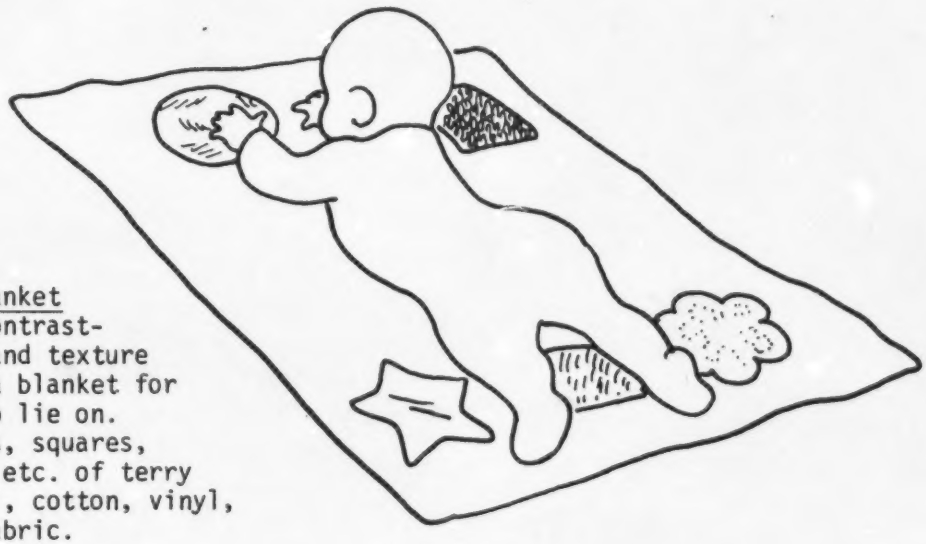
- You began to focus on a bright toy placed at a distance of 7" to 15" at _____ (days, weeks, months) s.

Reversible Color and Design Sign: (1) Glue one piece of construction paper to each piece of cardboard. Cover with contact paper (9"x12" cardboard--two pieces) (9"x12" construction paper--four or more colored pieces) (Clear contact paper). (2) Cut a notch in the middle of one side of each piece of cardboard. (3) Leaving a one-inch margin on each side, draw a bold design in the middle of each cardboard. (It's best if *simple* and *large*.) Make each design different. (4) Cut out the designs. (5) Glue the two cardboard pieces together, *colored side out*, along the *three unnotched edges only*. (6) Make a hole in the two unnotched opposite sides of the cardboard. Lace a piece of yarn through each hole (two 12" pieces of yarn or string). (7) Cut off one inch on three sides of the remaining pieces of construction paper. (8) Slip these two pieces of construction paper between the cardboard pieces at the notched edge (so different color shows through for each design). (9) Tie the board to the side of the crib within sight of the baby. Both the designs and the colors can be easily switched around.



- You were holding your head up for a few seconds at _____ s old and were able to hold your head up for as long as _____ when you were three months old!

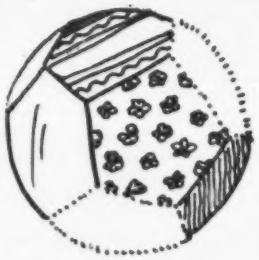
- You began to notice and be interested in different textures at _____ s old. You especially enjoyed the feeling of _____ _____.



Texture Blanket
Applique contrasting color and texture pieces to a blanket for the baby to lie on. Use circles, squares, triangles, etc. of terry cloth, wool, cotton, vinyl, corduroy fabric.

- You liked to wave your arms and Kick your legs. By the time you were _____ s old you would play with your toes or anything on your foot.

Sock Puppet: Measure lengths of yarn together, tie one end, braid the other end, tie. Sew middle of braid onto toe of a baby's sock. *Securely* attach a bell. Embroider nose, mouth, eyes or sketch in with indelible magic markers. Occasionally place sock on baby's foot when baby is awake and playing. *Remove bell when baby* is ready to take sock off or put foot in mouth to avoid the possibility of the baby accidentally choking on the bell.



Texture Ball Trace this pattern with tracing paper and and cut it out. Cut 12 of these out of assorted material scraps (wool, cotton, vinyl, terry cloth, corduroy, etc.). Using one piece as the center, sew five pieces to it, also sewing the sides together. Repeat these directions with the other six pieces. You now have two large pieces. Sew the two pieces together, leaving two seams open. Stuff with clean old stockings. Sew the last two seams closed.

- Right from the beginning I could tell that you could hear because when there was a loud, sharp noise you would _____. And when _____ or I would talk to you in a _____ voice you would _____.
- As you got a little older, about _____s old, you would turn your head and try to see where different sounds were coming from. When you were _____ s old, you would bat at things that made noise and you seemed sort of surprised that it was you who caused that noise. We spent a lot of time talking together. You would say _____, then I would say _____, and then we would both laugh.

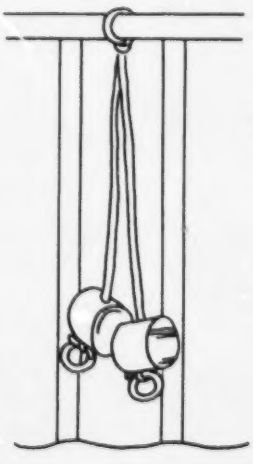
Songs and Rhymes

Sing "Rockabye Baby" or your own choice of song.

Say a rhyme while exercising the baby.

Up and down,
Up and down,
Baby goes
Just like a clown.

Sound Can Cradle Gym
Cut two frozen juice cans in half. Push holes for heavy cord through sides. Place a two-foot piece of cord through each with ends coming out through outside of cans. Tie a curtain ring at each end. Tie cans by cord to cradle gym on side of crib where baby can grasp for and bang cans together.



The Things We Did Together Three to six mos. (more or less)

- You were getting to be such a sociable baby. Sometimes you would say something like _____ to get someone to pay attention to you.
  (describe verbalization)

- You laughed out loud for the first time when you were _____s old.
  It was _____ that made you do it.
  (name of person or activity)

Ride a cockhorse to Danbury Cross,
To see a fine lady upon a white horse,
With rings on her fingers
And bells on her toes,
She shall make music wherever she goes.

Finger Play

There was a little mouse,
And he had a little house,
And he lived--up--here!

(Hold baby's hand open in yours; with your other forefinger make circles on baby's palm and at "Here!" Quickly walk your fingers up baby's arm to under chin, ear, etc.)

- We played lots of games together. Your favorite ones were:

_____ _____

_____ _____

They know their mother or closest caretakers and are more friendly and relaxed with them than with strangers. Brian and Shirley Sutton Smith, How to Play With Your Children.

- Mostly you laughed or smiled when anyone fussed over you, but by the time you were _____s old you began to cling to _____ and you didn't even like to have _____ hold you. You
(Daddy, Grandma, Aunt Sue, etc.)
were really showing us that you were smart enough to know that the person who had spent the most time taking care of you, you could trust . . . and you were sort of saying to everyone else "I'll trust you too, but not until I've had time to get to know you and know that you'll take good care of me."

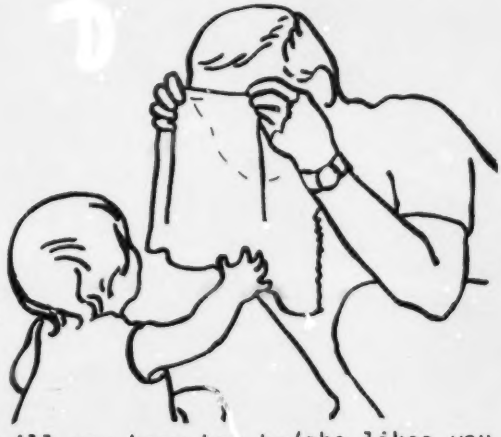
Some Separation/Practice Games Babies Enjoy

Place a clean diaper lightly and quickly over baby's face and ask

"Where's _____?"
(Mommy, your name)

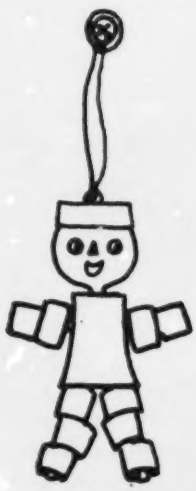
Hide and Seek while baby is sitting on your's or someone else's lap. Have second "important-to-baby person" call baby's name from where the baby can't immediately see the person. When the baby turns to find his/her friend, the friend pops out saying "Here I am!"

When the baby has learned to crawl, play a "Where's _____?" by getting down on the floor and searching for the baby behind the couch, down the hall, etc. until you find him/her with a happy "Oh there you are!"



Note: Only by observing your baby closely will you know how he/she likes you to play these and other games with him/her, and at what age he/she seems ready for different variations of them. Several good books on playing with baby are: (1) Beyond Peek-A-Boo and Pat-A-Cake by Evelyn Moatshunger and Susan Jane Bowdon; (2) Games Babies Play by Julie Hagstrom and Joan Morril; and (3) How to Play with Your Baby (And When Not To) by Brian and Shirley Sutton-Smith.

Give baby a Lid Puppet Doll to manipulate and chew on. (1) Lay about 15 assorted plastic or metal can tops on a table in the shape of a person, using the wider caps for the trunk and thinner caps for arms and legs. (2) Holding a large nail with a potholder, heat the nail over a stove burner. Then with the hot nail, melt two holes in the *top* of the *bottom* trunk cap. Melt two holes on the *sides* of the *upper* trunk cap. Melt one hole on the *side* of each foot cap. (3) Melt a small hole in the middle of the top of all the caps *except the feet and lower trunk*. Cut a hole in an empty lemon-shaped juice container. (4) Cut a long piece of thin elastic. String it through the arms and trunk. If dish soap nozzles are used for hands, tie a knot at each end. (5) Cut a piece of elastic and tie one end to the elastic in the lower trunk. Thread it through the other hole and thread the leg and feet caps. (6) Tie a knot around a button inside each foot. (This may be done at the arms too if no nozzles were used for hands. OR if you have no buttons, use nozzles instead inside the feet!) (7) Put a button on the elastic above the hat. Tie a loop and knot there. Make facial features with indelible marker, if desired.



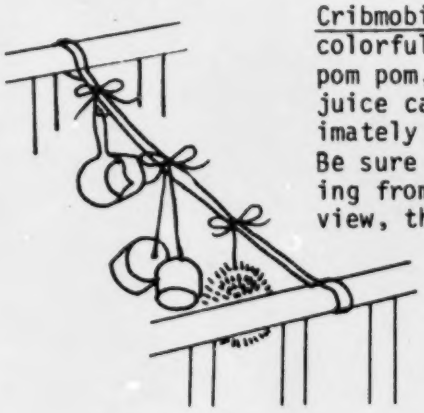
- You began to reach for and grasp your favorite toy, a_____, and before long you were able to put it in your mouth. This happened when you were _____s old.

Make a Pie Tin Mobile for baby to gaze at--better yet, let the older kids make one for each window.

How to use it: Hang the mobile securely to a window rod or ceiling fixture within the sight of the infant. *The objects should be out of the reach of the child!* The mobile will move in the breeze.

Instructions: Punch small holes in a pie tin with a hammer and nail to make a design. (Place the area to be punched over the open end of an empty can.) If the edges of the holes are sharp they can be flattened with the unopened end of the can. Hang the tin with yarn. OR: Punch holes as described above along the *rim* of the pie tin. Also punch one hole in the *middle*. Thread yarn through the holes. Hang assorted colorful household objects from the yarn attached to the rim. Tie a fat knot at the other end. Balance them! Tie a knot around a button on the bottom side of the middle piece of yarn. Make a loop at the other end, and hang the mobile by this loop.

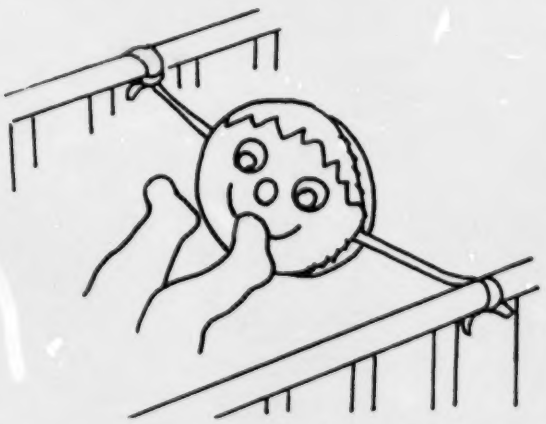
- By the time you were _____s old you could see much farther away than when you were just a tiny baby. We would hang _____ (toy to focus on or bat at) in/on the_____ and you would look at them and sometimes talk to them for a long time.
- Soon you were noticing that it was <u>your</u> hand that made the cups and things on your cribmobile swing, jingle and rattle. By the time you were _____s old you would spend _____ minutes at a time touching and batting at those toys. The _____ seemed to be your favorite item.



<u>Cribmobile</u> Hang any safe, colorful objects such as yarn pom pom, measuring cup or frozjuice can, cut in half, approximately 12" from baby's eyes. Be sure the mobile is interesting from the baby's point of view, that the items are securely attached and that the string is short enough not to be hazardous.

- When you were _____s old you got a real kick out of any toy we hung across your crib where you could reach it with your foot.

<u>Stuffed Kick Toy (Thumper)</u> Cut out two circles of colored polyester felt, each about one foot in diameter. Cut out facial features and sew them securely to one of the circles. Sew two pieces of elastic securely to opposite sides of the other circle. Sew the outsides of the circles together, leaving a three-inch opening. Stuff with fiberfill until nice and fluffy. Sew the opening closed. Attach the ends of elastic to the crib sides so that the stuffed pillow is within kicking distance of the child.



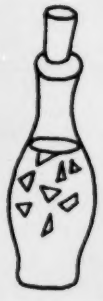
OR: Attach bells *securely* to any stuffed toy or stuffed pajama bag, hang where baby can kick at it.

You can reach it, just stretch a little further!

- When we put you on the floor on your tummy when you were _____s old, you _____ _____ (describe arms, legs, trunk movements) but later when you were _____s old, you actually _____ (describe movements) so you could reach a _____ (toy) that was at least _____ inches away from you. You should have seen the look on your face when you got to it all by yourself--it was _____.

Grasp Toy

Place some colored water and some colored shapes in a clear plastic bottle or string bells on a shoelace, then tie and place in bottle. Glue cover on securely with epoxy or "superglue."



Note: Some experts believe that babies should be provided with devices that help them sit and walk to better explore the world as early as possible. Others feel that it is better for babies to learn and progress naturally on their own without these devices. If you agree with the first group you will want to provide walkers, jumpers and other sit-in devices. (Caution: Overuse of these items may cause the baby to become overly dependent on them). If you agree with the second group, you will want to provide plenty of opportunities (open floor space, safe things to pull themselves up on) and words of encouragement as they learn to move from one position to another.

- It gave you a feeling of being with the family when we put you in the _____ so you could sit up safely and watch
(Box, Ring-Around-The-Baby)

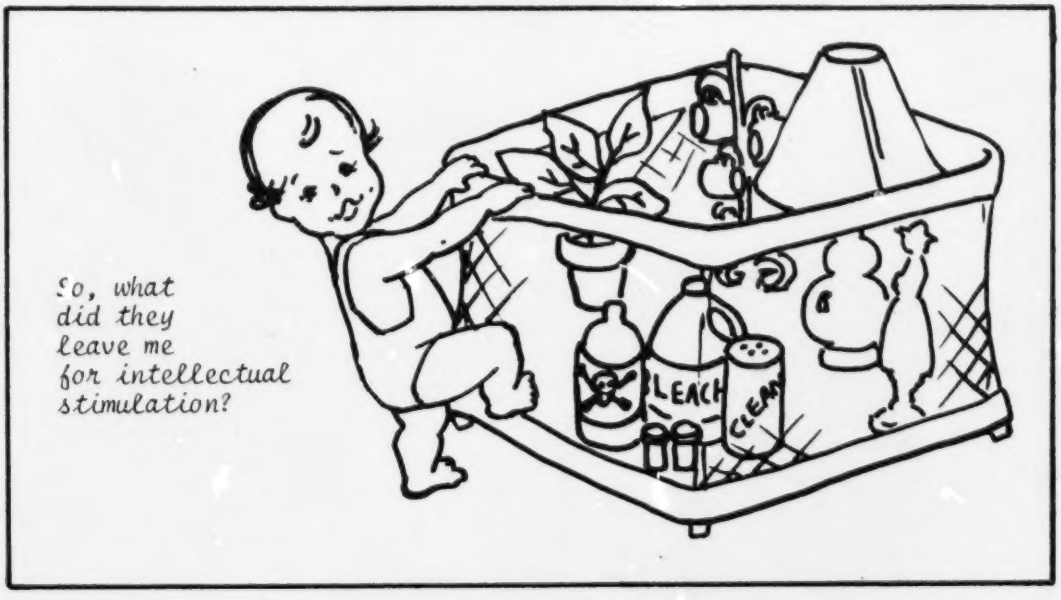
what was going on.

Ring-Around-the-Baby

Materials needed: Two pieces of fabric 2'x6'. Liner fabric must be tightly woven, waterproof fabric. Cover fabric should be sturdy and washable. Liner: Cut fabric to measure 5'8"xl'10". Sew the two long sides and one short side together to form a tube. Fill loosely with any suitable (available) material such as shredded foam, bean chair pellets, cut-up nylons. Stitch the final seam. Test to see if it will bend into a horse-shoe shape. Cover: On the right side applique colorful shapes or designs of various textures. Sew long sides together. Hem each end, leaving an opening large enough for cords to fit through. Thread 2' long cords through each hem. Place liner inside the cover. Pull cords tight and tie at each end. Bend into horseshoe shape. Adjust Ring-Around-the-Baby to baby's size and tie end cords together.

The Things We Did Together Six to 14 mos. (more or less)

I cannot overemphasize how important freedom to explore is in education of the young baby. It not only has its obvious primary utility of helping to deepen and broaden his curiosity, but will also facilitate his social development, another important goal of this period, by maintaining and deepening his interest in you. Burton White, The First Three Years of Life.



In plain English, what Burton was telling us parents here was that no matter how much easier it would have been on us and the house to pen you up, you had to have every chance we could give you to try out your arms and legs, hands and feet, fingers and toes, so that you could get going on exploring all those things you had been eyeing the last few months.

- So, up went _____ and _____.

  Some other changes we had to make were_____

  _____

  _____

- It was worth it, though, because one day when you were _____s old, you flipped yourself over from your _____ to your _____.

  You worked real hard at learning the next steps for using your body.

You:

- got up on your hands and knees for the first time at _____ months old.
- scooted backwards at _____ months old.
- scooted forwards at _____ months old.
- pushed yourself into a sitting position at _____ months old.
- crawled on hands and knees at _____ months.
- put yourself into a sitting position from a crawling position at _____ months old.
- began crawling from a sitting position at _____ months old.
- crawled over _____ (pillow, bolster, low box) when you were _____ months old.

- pulled yourself up to a standing position _____ (where) at _____ months old.
- liked to stand and bounce on _____ (person)'s lap while _____ (he, she, I) held your hands at _____ months old.
- began to take sideways steps along _____ (where) while hanging on with your hands at _____ months old.
- the first time you got yourself into a tight spot with your newly developed skills was when you _____ at _____ months old.
- liked to have _____ (person) walk with you by holding your hands when you were _____ months old.

- By the time you were _____s old you could use your pincer grip, that is you could pick up even the tiniest pieces of junk using your thumb and your forefinger. And because by now you could see better than at any other time in your life, _____ had to make sure that there wasn't a
(I, we, etc.)

thing that you could lay your fingers on that would hurt you, because everything you saw you picked up and usually popped in your mouth. You would have eaten an ant had you found one! Speaking of eating:

- By _____ s old you were eating _____
(types of solids)

along with drinking milk from _____.
(cup, breast, bottle)

When you had all you wanted, you let me know by turning your head to one side as a signal to stop feeding you. In order to help you understand that food was for eating and that toys were to play with when you sat in your high chair, I would simply remove what you had left of your food when you started throwing it around, and offered you some toys in its place. Some of your favorite foods were _____

_____

_____

_____

_____

_____

_____

- By now you weren't only interested in what the objects were like, you seemed really interested in what you could do with them. You especially liked to _____ balls, _____ blocks and _____ boxes.

- You were fascinated by the fact that you could let go of things on purpose and you started a game of "I drop it, you pick it up" when you were _____s old.

- By the time you were _____s old I decided to see if you could figure out how to get your own toy, so I tied _____ to a string and tied the other end to the arm of your high chair. After a few _____s (amount of time) of working on it you got it.

Your first artistic attempt was when you were _____ s old.

You made _____
(marks with crayon disc, nontoxic marker, etc.)

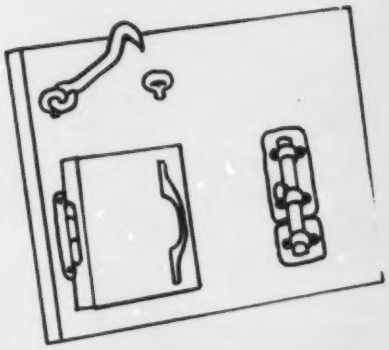
Nesting Cans

Use five or six cans (boxes or tubes) of increasing size. (1) Go around the rim of each clean can several times with the can opener to make sure there are no sharp edges. (2) Cut contact paper one inch *longer* than each can. Cover each can with the contact paper, folding the extra over the rim. put the cans inside each other.

- Since you loved hinged things, I let you have _____ to yourself. (box with lid, cupboard door, toy)

  Some other things you especially liked to play with were _____

  _____.



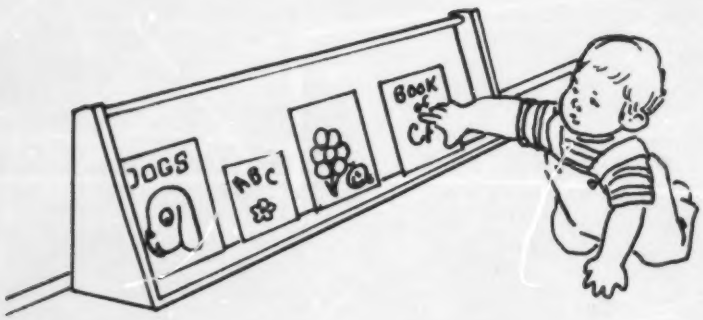
- When you were _____s old it was time to teach you to climb up and down stairs safely. You learned this by _____

  _____.

After that I didn't worry quite as much about you, should someone accidentally forget to close the gate or a door.

- I wanted you to become a good reader so we started looking at pictures in _____ (books, catalogs, magazines, junk mail) when you were only _____s old. At first you were only interested in _____ (turning, patting, etc.) pages, and I knew that was your way of learning all about the whole book. (See Books for Babies, p.

- As you got older you became more and more interested in the pictures. You pointed at them and made sounds like "_____," just as if you were reading to me. By the time you were _____ s old, you were picking out books for us to read together. Your favorites were _____ _____.



Sandwich Bag Picture Book (1) Cut a piece of tagboard to fit inside four to eight plastic "Ziploc" sandwich bags, equal to height and 3/4" *shorter* than the width of the bag. (Measure the bag with the open end on the left.) (2) Cut out pictures from magazines and glue them to each side of the tagboard pieces. (3) Slip each piece of tagboard into a plastic bag, with the open end of the bag at the left. Sew the open ends together securely with needle and thread.

- By now you were really getting into playing games. Some of your favorite games were _____.

  You even did the motions to _____.

Finger Plays

Jack-in-the-Box

Jack-in-the-box (Hands closed,
Sits so still. thumbs inside)

Won't you come out? (Thumb "jumps" out)
Yes! I will!

Clapping Song

(Help your baby clap hands, then hide them behind his back)

Clap your hands, one, two, three,
Play a little game with me.
Now your hands have flown away.
Come back hands so we can play.

Say "baby" finger play or sing to tune of Six and Twenty Blackbirds

Here's a ball for baby,
(Hands form ball)
Big, soft and round.

Here is baby's hammer,
(Pound fist)
Oh how she can pound.

Here is baby's music,
(Clap hands)
Clapping, clapping so.

Here are baby's dollies,
(Hold fingers up)
Standing in a row.

Here is baby's trumpet,
(Hands form horn)
Too too toot, too too.

Here is the way that baby,
(Hide face)
Plays peek-a-boo.

Here is a big umbrella,
(Hands open umbrella)
To keep baby dry.

Here is baby's cradle,
(Rocking motion)
Rock-a-baby-bye.

- Your babbling was beginning to sound more like real talk, in fact you would put this crazy string of sounds together like this "_____ _____" and end them with a "_____." Since I couldn't understand your jargon I tried to guess what you meant. By the time you were _____ s old, you said your first word _____, and soon you said _____, but you kept up the jargon until you were _____ s old. We had to remember that it was important for you that we listen when you were talking and you always politely listened to us.
- You wouldn't talk to just anybody anymore though, by the time you were _____ s old, you were definitely very shy with strangers and would associate with them only if _____. You also wouldn't let _____ out of your sight. It helped when you started to _____ since then you could control the distance between us.
(crawl, walk)

The Things We Did Together 14 to 24 mos. (more or less)

- At about _____ of age, you wanted very much to show us, and yourself, that you could do things for yourself and make your own decisions. You showed this by _____

_____

_____

- Sometimes when things didn't go your way, you would become very angry. Then you

_____

To help you learn to handle your feelings of anger without hurting yourself or anyone else, I would _____

_____

_____

until you were ready to play again.

I know you're feeling angry. I'll hold you until you are ready to play again.

- You were so interested in everything! That meant that when you were playing with someone you usually wanted to play with whatever they had. To help you learn to play with them rather than fight with them, I tried to have enough for each of you of the same toys. Some of the things that worked well were_____

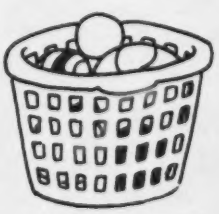
_____

_____

_____

_____

_____



Note: This surge of independence in the toddler is due to a new understanding of themselves as independent persons along with a lack of confidence in their own autonomy or rights as a person. Between 14 and 36 months toddlers test the world around them to identify where they fit into the scheme of things. They like to do things themselves and often say "no" to adult commands even though they will eventually obey.

- I really had no way of knowing for sure when you would be ready for toilet learning, since that depended alot on when your nervous system matured to the point where you could control your sphincter muscles. But in the meantime we began toilet learning by letting you in the bathroom when _____ (Daddy, Brother) or _____ (Mother, Sister, Aunt) had to urinate or have a bowel movement. Then we got you a _____ so you could begin to practice _____.

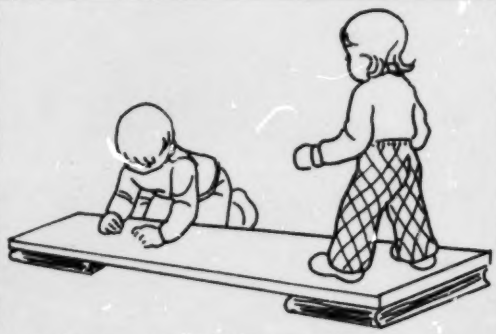
Children at this age often experiment with different ways of "going to the bathroom"

- We also read*_____ _____ together to help you get the idea. Some other things we did to help you learn to go to the toilet like big people were _____ _____ _____

- By the time you were _____s old, you stayed dry all night. And by the time you were _____s old you actually _____ in the _____. We were both so proud of you! Of course, I knew that it could be quite a long time yet before you could go all day and night without any accidents. (For most children none of this happens until after age 24 months. Just be patient and understanding of your child if he isn't ready to learn toileting yet.

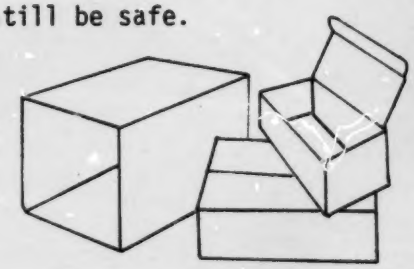
*No More Diapers! by Joae Brooks. Toilet Learning by Alison Mack.

- By the time you were _____s old you were so busy practicing your large muscle skills _____ that you hardly had time to eat or sleep. Your favorite body feats were _____



Balance Board to crawl on, balance on. Any board on two equal size books. The board should be looked over carefully for splinters or sharp edges.

- To help you practice those skills we provided you with _____ _____ that you could practice on to your heart's content and still be safe.



- Even though you were getting pretty smart, I knew that you still didn't have any way of judging the real dangers you could get into so _____ continued to keep a real close eye on you.

Carpet Puzzles (1) Use a piece of cardboard for a cutting surface so you don't mar your table. Cut pieces of carpet or carpet samples with a matte knife to make puzzle pieces. (2) For puzzles cut out of shag rug, put glue along the cut edges of all the pieces. This will keep the threads from pulling out. (3) Glue a piece of carpet on the lid of a cardboard box. Put puzzles in box for storage.

- When you weren't busy climbing, jumping, kicking, throwing, running, etc. you really got into practicing your eye-hand coordination. Some of your sitting down for _____ (seconds, minutes) activities were _____

_____

_____

- By 18 months you could stack _____ (number of blocks) on top of each other and by 24 months _____ of blocks. Whenever you built something like a block tower or made what looked to me like a "saver" picture, you would usually knock the tower down or scribble all over the picture and sort of ruin them. That's when I had to remind myself that what was important to you was just doing it, not the final product. To help you feel good about what you were doing, I would say (for an example) "_____" when you _____ (list typical activity). Then relax when you destroyed it, knowing that you had to in order to practice _____ _____ it again.

- I found out that it was a lot easier on both of us if I planned ahead and had some special activites that you could practice your small muscle skills on. Sometimes we did them together and sometimes you enjoyed doing them alone while I did other things.

Disc Crayons (1) Collect old crayon pieces. (2) Place in muffin tins. (3) Place in warm oven until just barely melted into a mass. Cool quickly. Baby will enjoy different colors his marks make. Otherwise, provide chubby or cone crayons which can be purchased.

- During this time you began to deliberately make certain kinds of scribbles. You began with _____ at 14 months old, made _____ at _____ s old, made _____ at _____ s old, made _____ at _____s old, made _____ _____ at _____s old, made _____ at 24 months old. I wrote down your age on some of your scribble papers and then we saved some of them in a _____

Edible Peanut Butter Play Dough
1 18-oz jar of peanut butter
6 tbsp. honey

Mix with dry milk until it has the right consistency for holding. Raisins make a great addition. Note: Be sure the little hands and working surfaces are scrubbed clean before starting.

- You _____ (liked, did not like) to mess with things like fingerpaints, playdough, etc. Since I knew this was a good way for you to learn about textures and how you could change and control materials, I would let you play with _____.

Finger Paints

3 Tbsp. sugar
1/2 cup cornstarch
2 cups cold water
Food coloring

Mix sugar and cornstarch add water, cook and stir over low heat until well blended and thickened. Divide into several containers adding preferred food coloring.
OR:
Give your toddler some prepared pudding to finger paint with. Again, *remember clean hands before the project starts.* Hint: To help the toddlers distinguish between when it's okay to mess and when it is not, use something like a large plastic lid (as from a 5-qt. ice cream bucket) or similar container to be used only for finger painting in.

Play Dough

Mix: 1 cup flour
½ cup salt
2 Tbsp. vegetable oil
1 tsp. alum (may be purchased at either grocery or drug store)

Add: 1/3 to ½ cup water

Stir in small amounts of water until consistency of bread dough. For colored dough mix food color to the water or to the finished dough. Store in air-tight container in refrigerator. Keeps well. *NOTE: Due to high salt content don't allow toddler to eat it.*

- Sure was alot easier than cleaning up spilled flour, vaseline smeared all over or a number of other things you might have found on your own. Of course there was always the chance that you would still find something on your own to experiment with, like the time you _____ _____ ___. That helped me realize that I needed to find more things for you to practice _____ _____ on.
(type of activity)

Testing himself against reality is about the most important thing human beings can learn. It is our definition of sanity. Sara Bonnet Stein, New Parents' Guide to Early Learning..

- By the time you were _____ s old, you brushed your teeth every day; by _____ s old, held and drank from you cup by yourself, and by _____ s old, you fed yourself with your own spoon (with a little help from your fingers, of course).
- By _____ of age you seemed to understand most simple words and instructions like _____

_____

_____.

- You were the kind of a toddler who began saying words _____. At 18 months you said _____
(late, early)
and by 24 months you said _____
(number of words, the words themselves, or kinds

_____.
of sounds if not saying words yet)

Finger Plays

Thumb in the thumb hole,
Fingers all together.
That is the song we sing,
When it's mitten weather.

Knock at the door	(Knock on forehead)
Ring the bell,	(Tug gently at hair)
Peep in,	(Open eye)
Lift the latch,	(Tweak nose up)
And walk in!	(Pop finger in mouth)

- To help you increase your ability to understand and use language, I would _____

_____

_____

_____

_____.*

*Note: At 18 months many children have an average vocabulary of 18-22 words, although some toddlers may wait until much later before talking. They typically use assorted meaningless syllables, which usually sound meaningful. To successfully encourage toddler's speech never correct or criticize, instead simply repeat the statement correctly, thus serving as a model. Also, talk out loud about what the toddler is seeing, hearing, doing, or perhaps feeling at that moment, and talk out loud about what you are doing, seeing, etc.

Thit . . .

Thill . . .

Jack-in-the-Box,
You sit so still,
Won't you come out?
Sure I will!

- Hold the baby with feet on the floor in a partial squat. As you recite "Won't you come out?" help the baby spring from his position. Later he can play this game alone.

- Although it was even harder for you to sit still now that you had so many things to explore and experiment with, I found that reading a book to you at _____ times was a good way to
(before nap, after nap, before bed, etc.)

_____ for you. Your favorite books at this time
(unwind, wake up, etc.)

were _____

_____

_____

BOOKS FOR BABIES

When selecting books for very young children, remember that their experience with the environment is limited and their greatest need is for security. Select books of appealing and familiar subject matter--nothing strange or scary. Both pictures and text should be simple, one object or thought per page. The illustrations should be photographs or colored pictures that are realistically portrayed. The appropriateness of a book is better determined from the child's interest and previous experiences with books, than the child's chronological age.

8 to 14 MONTHS

Generally speaking, a child is ready for his first book when an interest in fingerplays and games such as "pat-a-cake" is demonstrated. The child of this age will recognize pictures of familiar objects. The book itself should be durable since the child will probably try to taste, tear and throw it. Cloth books and board books with heavy cardboard pages are appropriate at this age. Colorful catalogs are invaluable for the child to practice with.

Fujikawa, Gyo. Babies. Grosset & Dunlap, 1963.
Fujikawa, Gyo. Baby Animals. Grosset & Dunlap, 1963.
Kaufman, Joe. Things in My House. Western, 1972.
Kundhart, Dorothy. Pat the Bunny. Western, 1962.
Matthiesen, Thomas. ABC, An Alphabet Book. Platt, 1968.
McNaught, Harry. Baby Animals. Random, 1976.
McNaught, Harry. 500 Words to Grow On. Random, 1973.
Ogle, Lucille. I Spy. McGraw, 1970.
Oxenbury, Helen. Family. Simon & Schuster, 1981.
Scarry, Richard. Early Words. Random, 1976.
Williams, Garth. Baby Animals. Western, 1956.

14 to 24 MONTHS

When baby begins to speak his first "real" words, then he is ready for books with a simple text. At this age pictures of familiar objects will be named spontaneously. Pictures of unfamiliar objects can be used to build vocabulary. The child begins to learn that pictures in a sequence tell a story.

Attenberger, Walburga. Who Knows the Little Man? Random, 1972.
Brown, Margaret Wise. Goodnight Moon. Harper & Row, 1947. Pbk also.
Burningham, John. The Blanket. Crowell, 1976.
Eastman, P. D. Are You My Mother? Random, 1960.
Fujikawa, Gyo. Mother Goose. Grosset & Dunlap, 1968.
Nakatani, Chiyoko. My Teddy Bear. Crowell, 1976.
Petersham, Maud & Miska. The Box with Red Wheels. MacMillan, 1949.

Rojankovsky, Feodor. Tall Book of Mother Goose. Harper & Row, 1942.
Welber, Robert. Goodbye, Hello. Pantheon, 1974.
Wikland, Ilon. I Can Help Too! Random, 1974.
Wikland, Ilon. See What I Can Do. Random, 1974.

NOTE: A set of books recommended for ages 9 MONTHS to 3 YEARS is:

Parish, Peggy. I Can--Can You? Greenwillow, 1980. This set of four small books was designed to encourage parents and young children to interact in such a way that the child's social, physical and emotional development is stimulated. "Jason can play peek-a-boo. Can you play peek-a-boo?" The colorful plastic pages, with rounded corners are nearly indestructible. The books show children growing a bit older and gaining new knowledge and physical skills.

HEALTH AND SAFETY BOOKS FOR TODDLERS**

Bruna, Dick. Mitty in the Hospital. Methuen, 1978. (Ages 2-7)
McGuire, Leslie. You: How Your Body Works. Platt & Munk, New York, 1974. (Ages 2-10)
Rockwell, Harlow. My Doctor. MacMillan, 1973. (Ages 2-7)
Rockwell, Harlow. My Dentist. Greenwillow Books, 1975. (Ages 2-7)
Watson, Jane, Werner et al. My Friend the Doctor. Western, 1972. (Ages 2-7)
Wolde, Gunilla. Betsy and the Doctor. Random House, 1978. (Ages 2-5)
Wolde, Gunilla. Tommy Goes to the Doctor. Houghton, Mifflin, 1976.(Ages 2-5)

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